EXHIBIT E

Document 13-6

Filed 08/07/2006

Page 3 of 134

Case 1:06-cv-00452-MEF-CSC

Notary Public

My Commission Expires:_

MY COMMISSION EXPIRES AUGUST 27, 2008 AO88 (Rev. 1/94) Subpoena in a Civil Case

Issued by the United States District Court

| MIDDLE | E DISTRICT OF ALABAMA | |
|--|---|--------------------------------------|
| JOWEL S. NUNN, | , | |
| | SUBPOENA IN | NA CIVIL CASE |
| V. | | |
| GREG WARD, et al. | Case Number: ¹ | 1:06-CV-452-MEF |
| TO: Wiregrass Medical Center 1200 W. Maple Ave. Geneva, AL 36340 | | |
| ☐ YOU ARE COMMANDED to appear in the testify in the above case. | United States District court at the plac | e, date, and time specified below |
| PLACE OF TESTIMONY | | COURTROOM |
| | | · |
| • | | DATE AND TIME |
| | · | |
| YOU ARE COMMANDED to appear at the p in the above case. | lace, date, and time specified below to to | estify at the taking of a deposition |
| PLACE OF DEPOSITION | | DATE AND TIME |
| / | | |
| YOU ARE COMMANDED to produce and per place, date, and time specified below (list do | ermit inspection and copying of the follocuments or objects): | owing documents or objects at the |
| Please see attached Exhibit A and Exhibi | t B | |
| | | |
| PLACE | | DATE AND TIME |
| you may mail the documents to the address | s below by the specified date. | 5:00 p.m. 07/21/06 |
| ☐ YOU ARE COMMANDED to permit inspect | ion of the following premises at the dat | e and time specified below. |
| PREMISES | | DATE AND TIME |
| Any organization not a party to this suit that is subp directors, or managing agents, or other persons who con natters on which the person will testify. Federal Rules | nsent to testify on its behalf, and may set for | |
| ISSUING OFFICER'S SIGNATURE AND TITLE (INDICATE IF A | TTORNEY FOR PLAINTIFF OR DEFENDANT) | DATE / |
|) and Fortham | Attorney For Defendants | 7/7/2006 |
| SSUING OFFICER'S NAME, ADDRESS AND PHONE NUMBER | } | |
| | | |

Daniel D. Fordham, Webb & Eley, P.C.

P.O. Box 240909, Montgomery, AL 36124-0240909 (334) 262-1850

(See Rule 45, Federal Rules of Civil Procedure, Parts C & D on next page)

¹ If action is pending in district other than district of issuance, state district under case number.

EXHIBIT A

ANY AND ALL CHARTS AND MEDICAL RECORDS, INCLUDING PRESCRIPTIONS, DOCTORS' NOTES, NURSES' NOTES, OPERATIVE NOTES, DISCHARGE SUMMARIES, CONSULTING PHYSICIANS' CORRESPONDENCE, CONSULTATION REPORTS, OFFICE NOTES OR MEMORANDA, HOSPITAL RECORDS, MEDICAL BILLS, REPORTS TO INSURANCE COMPANIES, X-RAY REPORTS OR OTHER DIAGNOSTIC REPORTS, CORRESPONDENCE TO OR FROM ATTORNEYS OR OTHER PHYSICIANS, OR ANY OTHER WRITTEN MATERIAL CONTAINED IN YOUR FILE OR IN YOUR POSSESSION REGARDING THE CARE AND TREATMENT OF JOWEL S. NUNN, SSN: 422-84-7896, DOB: 01/08/1977.

EXHIBIT B

HIPPA PRIVACY RULES' ASSURANCES

In accordance with the Federal Privacy Rules issued pursuant to the Health Insurance Portability and Accountability Act, ("HIPAA Privacy Rules"), we are providing you with the following satisfactory assurances:

- a. We have made a good faith attempt to provide the Patient, via the United States Mail, with a copy of this Civil Subpoena.
- b. The Civil Subpoena includes sufficient information about the litigation proceeding in which the medical and/or billing information is requested to permit the Patient to raise an objection.

Accordingly, following service of the Civil Subpoena, you may disclose the requested information in compliance with the HIPAA Privacy Rules.

In the event you cannot locate records concerning the Patient, please provide written notification to the requesting counsel. If you have any questions or concerns, please call the attorney for the Defendants, by contacting Daniel D. Fordham at (334) 262-1850.

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| ENT NUMBER 350235 | TYPE 3 | PATIENT NAME NUNN J | OWEL | | AG 2 | | 708/19 | 77 M | | DATE OF | /29/ | /98 | 1 1 | :58 | CLERK GM | INIT. R | |
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| SERVICE SESSES | PRE | 5/30/97 | IF MINOR - PAREN | TNAME | | | MED. R | 2847 (| 896 | FAMIL | Y PHYSIC | LER | J (| C/MI | LLEI | R J | C |
| CHARGES | X- | RAY LAB | RESP. TH. | РНҮ. ТН. | EK | G | i.v. | DRUGS | SUF | PLIES | ОТН | ER | M.D. | E.I | R. RM | TOTAL | DUE |
| The undersig | ned has be | een informed of the eme | ergency treatment cons | TON FOR TREATME | the above | named patient | t, and that treat | ment and pro | cedures will | be perforr | ned by ph | ysicians, n | embers | of house sta | aff and em | ployees o | of the |
| results that m 2. The undersign | ay be obta ned agrees | to pay for services ren | dered by Hospital upor | release of patient. | | | | | | · . | | | | | | nade as t |) the |
| I/we hereby a | uthorize th | hospital benefits, sick b ne "Administrator of Hos attorney to endorse for | pital" to furnish from its | s records any informa | ation reques | sted by the bef | fore mentioned | insurance co | mpanies in d | connection | with the | above assi | gnment. | i do hereby | appoint th | ne "Contro ital. | oller" |
| DATE | 13.17.77.4 | TIME | | SIGNED PATIENT | | | | | SIGNE | ANTOR | | | | | | | |
| ORDER OF | DA | Accident State Hov | w, when, and wh | ere) | | | | | | | | | | | | | |
| | | T | | | · · · · · · · · · · · · · · · · · · · | * | | | | | | 1 | HYSICIAN | | | | |
| TEMP PULSE | RESP. | B/P ALLERGIE | | | ME | EDICATIONS | | | <u> </u> | | | E.R. P | HYSICIAN | | | TET. TOX | · . |
| NURSES NOTES | S: | ************************************** | | | | | | | | | | | | | tı , | | |
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| LAB DATA (inclu | ding X-F | Rays, EKGs, etc.) | | | | | | | ٠. | | | | | | | | |
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| PHYSICIAN'S RE | PORT: | | | | | | | | | | | | | | | | |
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| REATMENT: | | | | | | | | , | | | | | | 00110 | | | _ |
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| NSTRUCTIONS T | O PATIE | ENT: | - W | | | | | | | | | | | | | | _ |
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| | | | | | | - | | | | | | | | 7 = | | M. | D. |
| F | ATIENT'S | SIGNATURE ON DISCHA | IRGE | | | DATE - TIME | OF DISC | | | | | PHYSICIAN | 'S SIGNA | TURE | | Wi. | <u></u> |

Case 1:06-cv-00452-MEF-CSC Document 13-6 Filed 08/07/2006 Page 13 of 134 350235 MILLER J C HD E.R. WIREGRASS HOSPITAL DOB-01/08/77 21 NALE GENEVA, AL 36340 ER MEDICAL RECORD ER/ROOK () EMERGENT () URGENT () NON-EMERGENT ADDRESSOGRAPH male evidence Collection TIME 12, $_{\rm TEMP}_{\it -}9$ PULSE_& TET _____WT ____ Tylenol BRV ____NURSE SIGNATURE ___ PHYSICIAN'S HISTORY AND PHYSICAL: CG PSH ____ SOCIAL ___ _FAM Hx __ ALLERGIES _____ ____MEDS _____ PE/VS __ HEENT ___ HEART/CV ABD//RECTAL NEURO INI MEDICATION PHYSICIAN'S ORDERS: CBC() _____CHEM (7)(24) __ ABG() ______ AMYLASE() _____ _____CT() UA(ROUT)/(CATH) F&E() US()____ CM() ____O2() ____FOLEY() ____IV: ____OTHER: ____ DISPOSITION: HOME() DR. OFFICE() SURGERY() EXPIRED() ADMIT RM#/ICU ______AMA/L WBS() DATE/TIME ABO 5-29-98 ____VIA ____ _____C/O DR _____ TRANSFER TO CONDITION AT DISCHARGE/TRANSFER: IMPROVED() STABLE() DETERIORATED() INSTRUCTIONS TO PT:_____

PHYSICIAN'S SIGNATURE:

FAMILY DR. Mone

WIREGRASS HOSPITAL

GENEVA, AL 36340

NUNN JOWEL 350235 MILLER J C ND DOB-01/08/77 21 MALE

E.R. NURSING ASSESSMENT SHEET

05/29/98 Addressograph NODE OF ARRIVAL: ()AMBULATORY ()WHEEL CHAIR ()STRETCHER ()AMBULANCE ()ARMS ALLERGIES: ACCOMPANIED BY WASELF () FAMILY/FRIENDS ROLICE ()OTHER FAMILY DR.:_ TIME & INI DR. CALLED TREATMENT PTA: ()C COLLAR ()SPINE BOARD ()CID TIME & INI DR ARRIVED_ BREATHING TX___ AIRWAY: ()ORAL ()ET TUBE O2:____()NC ()MASK EKG____ NOTIFIED: ()POLICE NG TUBE_ MONITOR___ DRESSING:_____ ()OTHER: DRESSING O2 V FLUIDS:____ WHOM_ ABG_ FOLEY___ RESPIRATORY: (NORMAL ()SHALLOW ()DEEP TIME_ OTHER X-RAY_)RETRACTIONS ()LABORED ()RAPID ()SLOW PATIENT VALUABLES GIVEN TO_ _()HOSP SAFE RESPONSE BREATH SOUNDS: (SCLEAR ()RALES ()WHEEZES TIME | MEDICATION ROUTE SITE COUGH: ()NON-PRODUCTIVE ()PRODUCTIVE CIRCULATION: SKIN ()WARM ()DRY ()COLD ()DIAPHORETIC ()HOT ()CLAMMY COLOR: ()NORMAL ()DUSKY ()FLUSHED ()PALE ()CYANOTIC ()JAUNDICED MENTAL STATUS: ALERT (ORIENTED INI SITE RATE SIZE ()DISORIENTED RESPONDS TO: (VOICE) (PAIN) TIME TYPE IV ()LETHARGIC ()UNRESPONSIVE PUPILS/(EQUAL)/(UNEQUAL) FIXED:(PINPOINT)/(DILATED) SIZE: INSERT SIZE CHART HERE> VISUAL ACUITY: OD:_____/20 OS:____ ABDOMEN: BOWEL SOUNDS: (PRESENT) (ABSENT) ()DISTENDED ()TENDER ()RIGID ()SOFT EXTREMETIES: ()WNL ()EDEMA ()COOL ()WARM_ ROM YN DEFORMITY: YLD SENSORY: Y/N CAPILLARY: sec PULSE: GU/GYN: ()DYSURIA ()FREQUENCY ()HEMATURIA ()VAGINAL BLEEDING ()DISCHARGE: VAG/URETHRA ACERATION: BLEEDING: Y/N / SPEE: OCATION:_ TITLE INI EMOTIONAL: AFFECT WILL FLAT ()COOPERATIVE NURSES SIGNATURE: . EYE CONTACT/X/N ()AGITATED ()HOSTILE ()ANXIOUS)COMBATIVE

| · | ED-OP | | | | | | |
|--|--|---|--|--|--|--|--|
| WIREGRASS HOSPITAL | | NSTRUCTION SHEET | | | | | |
| 1200 W. MAPLE AVE. | 1. MEDICAL RECORD NO. | 2. BILLING NO. 3. A/R NO. | | | | | |
| GENEVA, AL 36340 | | VISIT INFORMATION | | | | | |
| 205-684-3655 | NUNN JOWEL 4. CLASS 5. DATE E. R | | | | | | |
| 10. PATIENTS LEGAL NAME (L.F.MI) | 1. SEX 12 PACE 13 BITTH DATE 14. AGE 15. HEIGHT | 16. WEIGHT 17 SS 18 MS 19. , | | | | | |
| | DQE-01/08/77 2 MALE | | | | | | |
| 20. RP 21 NOTIFY IN EMERGENCY | 22. HOME 23. WORK 24. HOW PATIENT AF | RIVED | | | | | |
| | E8/ROOM | No. | | | | | |
| 25 C COMPLAINT 26 | 27. PROC CD 28 PROCEDURE | NT SURGERY INFORMATION 29 LOC 30. TIME 31 ANES | | | | | |
| 32 PHYSICIAN CALLED | P PRIVATE PAY 133 ATTENDING PHYSICIAN | 34 FAMILY PHYSICIAN | | | | | |
| a moone car | | * | | | | | |
| SPRAIN, FRACTURE, & SEVERE BRUISES | BACK AND NECK INJURY INSTRUCTIONS | HEAD INJURY INSTRUCTIONS | | | | | |
| Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for | ☐ USE HEAT OR COLD ON THE INJURED AREA—whichever seems to help the most. Be careful not to burn yourself ☐ Rest as much as possible until you are improved | Persons who receive blows to the head may have injuries that cann always be seen by X-ray or examination soon after accident. For the next 24 hours it is important that these instructions be followed | | | | | |
| comfort ce packs also help prevent swelling, especially during the first | Avoid positions and movement that make the pain worse. | Awaken the patient every two hours, even at night, to be suit he knows where he is and is not confused. | | | | | |
| 48 hours. Place ice in plastic or rubber bag, cloth covering; after 48 hours, | Relax emotionally—if you are tense the problem will only be worse. | ☐ Check eyes to see that both pupils are of equal size. ☐ Prevent the taking of sleeping pills, tranquilizers or alcohol | | | | | |
| use heat. If you have an elastic bandage, rewrap it if too tight or loose. | Gentle but firm massage will increase circulation in sore muscles and helps to clear the soreness | Restrict excessive work or play. Call your family doctor or local hospital immediately if the patient | | | | | |
| Remove at bedtime and replace in A.M. If you have a cast, keep it perfectly dry at all times. | ☐ Wear special collar when out of bed | Develops a severe headache Vomits more than twice within a short time. | | | | | |
| Wiggle toes or fingers to help prevent swelling in the cast—this should be done often if it does not cause pain. | · | s confused, faints or is hard to awaken. Has a pupil of one eye larger than the other | | | | | |
| ☐ If the part swells anyway, or gets cold, blue or numb or pain | | ☐ Complains of double vision | | | | | |
| increases markedly, have it checked promptly Use crutches. | | Shows abnormal behavior such as staggering or walking int things. | | | | | |
| X-RAY INSTRUCTIONS | WOUND CARE (Cuts, Abrasions, Burns, Stitches) | VOMITING & DIARRHEA | | | | | |
| Your X-rays have been read by the attending physician in the | ☐ Keep the dressings clean and dry | ☐ Do not feed anything for 4 hours | | | | | |
| Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are | ☐ Elevate the wound to help relieve soreness and help speed | After 4 hours, if there is no vomiting and/or diarrhea, offer 2 tablespoons (1 ounce) of any of the following clear liquids | | | | | |
| found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emer- | Despite the greatest care, any wound can be infected. If your | Coke, Gingerale, 7-up, weak tea. Gatorade or Jello water to patient is hungry you may add 1 teaspoon of sugar to each | | | | | |
| gency Dept has a phone number where you can be reached.) Sometimes tractures or abnormalities may not show up on X-rays | | ounce of liquid. UNDER NO CIRCUMSTANCES USE MILK OR MILK PRO | | | | | |
| for several days, if your symptoms continue or get worse, call your doctor. More X-rays may need to be taken if you are referred to | | Ducts. | | | | | |
| another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray | ☐ Treatment rendered | The 2 tablespoons of liquid may be offered every hour if after 4 hours no vomiting has occurred, the amount may be slowly increased | | | | | |
| Dept. | 250 units of telanus immune globulin was given. To complete your immunization, you must receive two additional doses of | Using no more than ½ glass (4 ounces) of liquid at a time continue this treatment for 24 hours. | | | | | |
| | toxoid 4-6 weeks apart. Call your physician for the next dose. Warm soaks to area 4 times daily, 20-40 minutes each time | ☐ Contact your doctor's office for further instructions after 2- | | | | | |
| · | Continuous warm compresses. | hours | | | | | |
| GENERAL INSTRUCTIONS | FEVER OVER 102 | ANIMAL OBSERVATION | | | | | |
| Stay in bed/may go to bathroom. Use vaporizer. | Sponge with lukewarm water in the tub. | Instructions for observation of any animal that may have bitten a | | | | | |
| Use vaporizer. Drink large amounts of liquids. | If temperature increases or persists for 24 hours, see your family doctor | human if that animal is available for observation. Have animal taken to Veterinarian for observation. | | | | | |
| Take aspirin every 4 hours. | · | If the owner should refuse to take the animal to the Veterinarian. | | | | | |
| Avoid any use of injured part. Allow only limited use of the part. | | notify the County Health Officer of the situation. | | | | | |
| Allow only limited use of the part. You need not necessarily limit activity. | EYE INJURY ☐ Any eye injury is potentially hazardous. | | | | | | |
| Fill Prescriptions given to you from Emergency Dept. and take as directed. | Any increasingly severe discomfort, redness or sudden impair- | | | | | | |
| No driving or any activity requiring mental alertness after | ment of vision should be reported immediately to your physician or eye specialist below. | | | | | | |
| receiving medication. | ☐ Do not drive with eye patch. | | | | | | |
| ADDITIONAL INCTRICTIONS | | | | | | | |
| ADDITIONAL INSTRUCTIONS | | | | | | | |
| I hereby acknowledge receipt of all the instruction | ns indicated above. I understand that I have received E | MERGENCY treatment only and that I may be | | | | | |
| released before all my medical problems are know worsen or new symptoms appear, I should contact | wn or treated. I will arrange for follow-up care as indi | cated above. I understand that if my conditions | | | | | |
| | | PHYSICIAN'S SIGNATURE | | | | | |
| DOLLOGI, AND INDEX EVOLUCE DITTE | UT MAAF | , DATE | | | | | |
| | VT NAME | | | | | | |
| ☐ No work for days ☐ Light work for days | □ No school for □ No Physical Educatio | • | | | | | |
| ☐ May return to work on | | | | | | | |
| Wiregrass Hospital | | | | | | | |
| wiicyiass mospilai | PHYSICIAN'S SIGNATURE |) | | | | | |

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| WIREGRAS! | S MEDI | CAL CE | NTER | 12 | ØØ W MF | APLE AVE | | ENEVA | | | 36340 |
| ENT NUMBER | TYPE PATIE | NT NAME | | · | AGE BIR | THDATE SEX | | | OM • OUTP | PATIENT CERKE | |
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| HEEB47896 | 5 NI | JNN LI | NDA | | MOTHER | | _ | | | H-6598- | .9198 |
| RANCE COMPANY | | | | | CONTRAC | CT OR GROUP NUMBER | DATE | PLACE | | | / |
| | | | | | | | TIME | EVENT | | | $\overline{}$ |
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| ANTOR EMPLOYER ROOKS PE | EANUT (| 00 | GL | ABURE! | ATION | GUAR. EMPLOYER ADDRESS | | | GUAR. E | EMPL. TELEPHO | NE |
| 50235 | PREV. SERV | 9798 | IF MINOR - PARENT | NAME | | M쿠ટ11218 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | 96 FAN | "LYHÖRNS | BY K /S | NOMMI | IS J |
| CHARGES | X-RAY | LAB | RESP. TH. | PHY. TH. | EKG | I.V. DRUGS | SUPPLIES | OTHER | M.D. | E.R. RM | TOTAL DUE |
| hospital. Auth results that ma | norization is hereby by be obtained. and agrees to pay f | y granted for such | ency treatment consider treatment and processed by Hospital upon a | dered necessary for edures. The under release of patient. | or the above named rsigned has read the | OF PAYMENT, ASSIGNMENT OF IN patient, and that treatment and proce e above authorization and understan | edures will be perfo nds the same and | ormed by physician certifies that no gu | arantee or assurant | ce nas been ma | loyees of the |
| 3. I/we hereby as | sign any hospital l | penefits, sick bene | fits, injury benefits du | ue to a liability of a | ation requested by t | e by any party, for the above patient, t the before mentioned insurance comp ected under the above assignment an | panies in connecti | on with the above : | assignment. I do hei | reby appoint the | ; "Controller al. |
| CHEF COMPLA | NT (ILACCIDE | | When, and Whe | | | | | | | | |
| | <u>.</u> | | | | | | | , | | , | |
| TEMP PULSE | RESP. B/P | ALLERGIES | | · · · · · · · · · · · · · · · · · · · | MEDICAT | TIONS - HOME | | E. | R. PHYSICIAN | T | Ет. тох. |
| NURSES NOTES | : : | | | · · · · · · · · · · · · · · · · · · · | | | | | *** | | |
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| | | | | | | | | | NURSES'S SIGNAT | TURE (RN OR LP | 'N) |
| LAB DATA (Includ | ling X-Rays, E | KGs, etc.) | | | | | | | <u> </u> | | |
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| PHYSICIAN'S RE | PORT: | A. C | | | | | <u></u> | | | | |
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| DIAGI | 1001 | <u> </u> | | | | | | | | | |
| REATMENT: | W. | | | and the same | | | | | | | |
| | 4.1.44 | | | | | | | | CON IMP I | NDITION ON DISC | C EXPIRED |
| NSTRUCTIONS TO | O PATIENT: | | | | | | | | IMP | STABLE | EXPINED |
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| | | | | | | | | | | A/h | M.D. |
| | | | | | | | | | | | M.D. |
| ь. | ATIENT'S SIGNATI | IDE ON DISCHARG | 2E | | DATE | - TIME OF DISC | | PHYS | CIAN'S SIGNATURE | | |

Filed 08/07/2006

Page 21 of 134

Wiregrass Hospital 1200 W. Maple Avenue Geneva, Alabama 36340

360064

CONDITIONS FOR TREATMENT

required to pay in full immediately.

Date

Signature

- MEDICAL AND SURGICAL CONSENT FOR TREATMENT: The undersigned hereby authorizes WIREGRASS HOSPITAL to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.
- 2. RELEASE OF INFORMATION: The undersigned hereby authorizes WIREGRASS HOSPITAL to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.
- 3. RELEASE FROM LIABILITY FOR VALUABLES: I have been made aware that WIREGRASS HOSPITAL provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.
- 4. GUARANTOR AGREEMENT: The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.
- 5. ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS HOSPITAL for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

| such physician or organillness, the Part B deduced Date | Signature | Relationship to Patient |
|---|--|---|
| such physician or organ illness, the Part B deduc | | |
| other information about Medicare claim. I requ | t me to release to the Social Security Administrati est that payment of authorized benefits be made o | tle XVIII of the Social Security Act is correct. I authorize any holder of medical or on or its intermediaries or carriers any information needed for this or a related on my behalf. I assign the benefits payable for physician services or authorize to me. I understand that I am responsible for Part A deductible for each spell of ole charges and any personal charges incurred." |
| F | | IEDICARE BENEFITS: RELEASE INFORMATION, AND PAYMENT REQUEST |
| | ~ | Relationship to Patient |
| Witness AUC | () | Patient's Agent or Representative |
| K. | Rolling | Patient |
| PATIENT OR IS DULY | CERTIFIES THAT HE HAS READ OR HAD THE FOR AUTHORIZED BY THE PATIENT AS PATIENTS G | OREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE ENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS. |
| THE UNDERSIGNED | | THE A CORV AND IS THE |

Relationship to Patient

Case 1:06-cv-00452-MEF-CSC Document 13-6 Filed 08/07/2006 Page 23 of 134

PRINT DATE: 11/03/98

Wiregrass Hospital

Louis E. Seibert, M. D. 😤

01D0304961

CLIA Number

Medical Director TIME: 13:00

LABORATORY - - CUMULATIVE REPORT

NAME .: NUNN JOWEL

SEX..... M

PHY..: HORNSBY KEVIN

ACCT#: 360064 ROOM.: E.R.

AGE..... 21 Y - NO PENDING ORDERS DOB.....: 01/08/1977 ADMIT: 10/31/98 MR#..: 422847896

REFERENCE LAB

10/31/98 0838 10/31/98 0838 10/31/98 0846 11/02/98 1459

--ORDERED-- --COLLECTED-- --REC'D-- --RESULTED-- --VERIFIED---11/02/98 1459

CCH

FEW

 $_{
m LBT}$

LBT

GC & CHLAMYDIA DNA PROBES

SPECIMEN: MICRO SPECIMEN

LOC: ER

COLLECTED: 10/31/98 NO TIME

RECEIVED: 10/31/98 3:53PM

LOG #: E461244

REPORTED: 11/02/98 12:23PM

CLIENT #: 846

TEST

RESULTS H/L

NORMALS

REPORT NOTES: *** NON-FASTING ***

DNA PROBE: NG & CHL

N. GONORRHEA ANTIGEN

POSITIVE*

NEGATIVE

C TRACHOMATIS ANTIGEN

NEGATIVE

NEGATIVE

*** FINAL REPORT ***

Above test performed by Alabama Reference Laboratory; CLIA #: 01D0641677

Chief Medical Director R. B. Adams, M.D.

PHYSICIAN'S SIGNATURE: ___

FAMILY DR.

Document 13-6 Filed 08/07/2006 Page 27 of 134

NUNN JOWEL E.R. 360064 HORNSBY KEVIN

DOS-01/08/77 21 MALE

10/31/98

WIREGRASS HOSPITAL

GENEYA, AL 36340

NURSING ASSESSMENT SHEET

ER/ROOM 10-3/ TIME: 1 Addressograph MODE OF ARRIVALE ()AMBULATORY ()WHEEL CHAIR ()STRETCHER ()AMBULANCE ()ARMS ALLERGIES: ACCOMPANIED BY: () SELF () FAMILY/FRIENDS () POLICE () OTHER FAMILY DR.; DR. CALLED TIME & INI TREATMENT PTA: ()C COLLAR ()SPINE BOARD ()CID TIME & INI AIRWAY: ()ORAL ()ET TUBE O2:____()NC ()MASK EKG___ BREATHING TX___ DR ARRIVED NG TUBE NOTIFIED: ()POLICE MONITOR DRESSING:_ DRESSING () OTHER: O2 V FLUIDS:_ WHOM FOLEY___ ABG_ OTHER:_ RESPIRATORY: ()NORMAL ()SHALLOW ()DEEP TIME DTHER X-RAY_ _()HOSP SAFE)RETRACTIONS ()LABORED ()RAPID ()SLOW PATIENT VALUABLES GIVEN TO_ ROUTE SITE INI RESPONSE TIME | MEDICATION BREATH SOUNDS; ()CLEAR ()RALES ()WHEEZES COUGH: ()NON-PRODUCTIVE ()PRODUCTIVE CIRCULATION: SKIN JWARM JORY ()COLD ()DIAPHORETIC ()HOT ()CLAMMY COLOR: ()NORMAL ()DUSKY ()FLUSHED ()PALE ()CYANOTIC ()JAUNDICED MENTAL STATUS: ()ALERT / ORIENTED / 1 SITE RATE SIZE TYPE IV ()DISORIENTED RESPONDS TO: (VOICE) (PAIN) TIME. ()LETHARGIC ()UNRESPONSIVE PUPILS:(EQUAL)/(UNEQUAL) FIXED:(PINPOINT)/(DILATED) SIZE: <INSERT SIZE CHART HERE> NURSES NOTES: 0800) TO Exam Rm - LH (0820) (VISUAL ACUITY: OD:____ __/20 OS;__ ABDOMEN: BOWEL SOUNDS: (PRESENT) (ABSENT) ()DISTENDED ()TENDER ()RIGID ()SOFT EXTREMETIES: ()WNL ()EDEMA ()COOL ()WARM ROM: Y/N DEFORMITY: Y/N SENSORY: Y/N CAPILLARY:____sec PULSE:_ CU/GYN: ()DYSURIA ()FREQUENCY ()HEMATURIA ()VAGINAL BLEEDING /DISCHARGE: VAG/URETHRA LACERATION: BLEEDING: Y/N SIZE:_ LOCATION: INI TITLE NURSES SIGNATURE EMOTIONAL: AFFECT: (WNL) FLAT ()COOPERATIVE 6 EYE CONTACT: Y / N ()AGITATED ()HOSTILE ()ANXIOUS COMBATIVE URSE :

ED-OP **HOME INSTRUCTION SHEET**

| WIREGRASS HOSPITAL | | | | č | | HOME | INS | IKU | | N 21 | | = I | | |
|---|------------------------|----------------|--------------------------------------|-----------------------------|---------------------------------|---------------------------------------|---------|------------------------------|---------------------------|----------------------|-----------------|-------------------------------|--------------|----------------------------|
| 1200 W. MAPLE AVE. | | | F | | 1. MEDICAL RE | CORD NO. | 2 | . BILLING NO |), | | | 3. A/R NO. | | |
| GENEVA, AL 36340 | | - | ! | | | | | 95 | TINFORMA | T Ohe | | | | |
| 205-684-3655 | | | | | 4. CLASS | 5. DATE | | 6. TIME | | 7. SRC | 8. Т | YPE | 9. SAD | |
| Kilo Hallichis Regulinate (I.E.M.) | . SEX 12.F | RACE | 13 BIRTH DATE | 1 | 14. AGE | 15. HEIGHT | 16. V | VEIGHT | 17. SS | 18. MS | 19. , | | L | |
| 360064 HORNSBY KEVIN | . | | | | | | | | | | | | | |
| [20) FP 21 (MOTHY MEDICAL PAY 2] MALE | | номі | <u> </u> | 23. WORK | 1 | 24 HOW PATIENT A | VRRIVE | 5 | J | | | - | | |
| 10/31/98 | | ELE | | TELE | j | | | | | | | | | |
| 25 C COMPLAINT 26 | | | 27 PROC CD | 28. PROCE | DUGE | OUTPATE | ENT, SU | RGERY INFO | DRMATION | 29 LO | C | 30. TIME | C Floriday | 31. ANES |
| ER/ROOM | | | 27 FROC CD | 26.11100. | - DONE | | | | | | | | | |
| 32 PHYSICIAN CALLED | 33 ATTEN | DING | PHYSICIAN | | | | 34 | FAMILY PHY | SICIAN | | | | | |
| P PRIVATE PAY | <u> </u> | | | | | | | | | | | | | |
| SPRAIN, FRACTURE, & SEVERE BRUISES | E | BAC | K AND NEC | CK INJUF | RY INSTRU | JCTIONS | 1 | | HEAD | INJUF | Y IN | STRUC | ΠONS | |
| ☐ Elevate the injured part above level of heart to lessen swelling. | | | | | | REA-whichever | | | | | | | | that cannot |
| If pillows flatten, use chair cushions with pillows or blanket for comfort | N | | to help the mos much as possi | | | | | | | | | se instruct | | lent. For the llowed: |
| Lee packs also help prevent swelling, especially during the first | # <u> </u> | oid p | ositions and mo | ovement that | it make the pa | ain worse. | [| | | | | hours, eve | | , to be sure |
| 48 hours. Place ice in plastic or rubber bag, cloth covering; after 48 hours, | | lax (orse. | emotionally-if y | you are ten | nse the proble | em will only be | | Check | eyes to s | ee that b | ooth pu | upils are of oills, tranqu | equal siz | |
| use heat. If you have an elastic bandage, rewrap it if too tight or loose | | | but firm massag | | se circulation | in sore muscles | [|] Restrict | excessiv | e work (| or play | <i>i</i> . | | |
| Remove at bedtime and replace in A.M | B | | pecial collar wh | | ed. | | Ca | | nily doctor os a sever | | | ital immedia | ately if the | patient. |
| If you have a cast, keep it perfectly dry at all times. Wiggle toes or fingers to help prevent swelling in the cast—this | , | | | | | | | - | more than ised, faint | | | a short tim awaken. | e. | |
| should be done often if it does not cause pain | | | | | | | 18 | | iupil of one | | | an the oth | er | |
| If the part swells anyway, or gets cold, blue or numb or pain increases markedly, have it checked promptly | | | | | | | | | | | | n as stagg | ering or v | valking into |
| Use crutches | 14161 | | 0.05.10 | | | 000 1 1 | + | | 1/01 | ALTIA IC | | NADDIJE | | |
| X-RAY INSTRUCTIONS | . WOL | JNE |) CARE (Cu | ts, Abras | ions, Burn | s, Stitches) | | | VOI | MITING | 3 & L | DIARRHE | <u>-</u> A | • |
| Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be | _ | • | e dressings clea | • | | | 11 | Do not f | | - | | | ine diner | on offer 2 |
| reread the next morning by Radiology Dept If any abnormalities are | | | the wound to lealing | help relieve | e soreness a | nd help speed | | tablespo | oons (1 c | iunce) c | of any | of the fo | llowing cl | ea. offer 2 ear liquids |
| found that have not been called to your attention, you and your doctor will be called immediately (Please be certain that the Emer- | ☐ Des | onte | the greatest ca | are, any wo vollen, show | und can be in s pus or red s | nfected. If your streaks, or feels | | | s hungry | | | | | o water if ar to each |
| gency Dept has a phone number where you can be reached.) Sometimes tractures or abnormalities may not show up on X-rays | | | re instead of les doctor right av | | days go by. y | ou must report | | UNDER | | CUMSTA | NCES | S USE MI | K OR N | IILK PRO- |
| for several days if your symptoms continue or get worse, call your doctor. More X-rays may need to be taken if you are referred to | 1) | - | should be char | nged in | days | | | DUCTS. | hlesnoon | s of kau | ıd mav | , be offere | d every h | our If after |
| another physician, come by the hospital and pick up your X-ray and | | | nt rendered Toxiod given | | | | | | no vomitii | | | | | be slowly |
| take them with you to the doctor's office. Please call ahead to X-ray Dept. | 250 | unit | s of tetanus im nunization, you | | | | | Using no | more th | | | | of liquid | at a time. |
| | toxo | id 4- | 6 weeks apart. | Call your p | hysician for th | ne next dose. | | | this treat | | | | nstruction | s after 24 |
| | l | | aks to area 4 ti us warm compr | | 20-40 minutes | s each time | 1 | hours | | | | | | |
| OFNEDAL INSTRUCTIONS | | <u>—</u> | CEVIC | R OVER | 2 102 | | ╂ | | ΔΝΙΙ | MAI (| BSE | RVATIO | NI | |
| GENERAL INSTRUCTIONS Stay in bed/may go to bathroom | | | reve | IN OVER | 102 | | | | | | | | | |
| Use vaporizer | | | e with lukewarn | | | hours, see your | I hair | ructions fo nan if that a | r observa animal is a | ation of vailable | any a for ob | animai that oservation. | may hav | e bitten a |
| Drink large amounts of liquids | | | doctor. | ises or per | 31313 101 24 | riodis, see your | | Have anii | mal taken | to Veter | inariar | n for obser | vation. | |
| Take aspirin every 4 hours. Avoid any use of injured part. | | | | | | | | | | | | the anima | | eterinarian. |
| Allow only limited use of the part | | | EV | Æ INJUF | | | 1 | nouty the | County | realiti O | meer | or the situe | illost. | |
| You need not necessarily limit activity. | ☐ Ar | пу еу | ا ے e injury is poter | | | | | | | | | | | |
| Fill Prescriptions given to you from Emergency Dept. and take as directed. | ☐ Ar | ny ind | creasingly seve | re discomfo | ort, redness or | r sudden impair- lo your physician | | | | | | | | |
| No driving or any activity requiring mental alertness after | or | eye | specialist belov | w. | mmediately . | o you physical. | | | | | | | | |
| receiving medication. | ☐ Do | not | drive with eye p | patch. | | | | | | | | | | |
| ADDITIONAL INSTRUMENTALIS CALL | h () | 7 | · · - | | $\overline{}$ | day | | C | 1 | 11 | 10 | | | |
| ADDITIONAL INSTRUCTIONS | <u> </u> | <u>ب</u> | | \ | | Ciay | | Ţ_C | AZ | 70 | | | | |
| - Culture rg | 1 1 h | _ | -60 | | | | | DOENO | V 4===1 | | | and the | A. I. | |
| I hereby acknowledge receipt of all the instruction released before all my medical problems are know | is indica in or tre | ted eate | above. I un d. I will arr | nderstand ange for | tnat i na follow-up | ve received care as inc | licate | ed above | r treati e. I unde | erstan | only d tha | and tha atifmny | conditi | ons |
| worsen or new symptoms appear, I should contact | my Doct | or i | mmediately. | | • | | | | | | | | | |
| ATTENT'S SIGNATURE | NURSE'S S | SIGN | ATURE \ | | | | PHY | SICIAN'S S | IGNATUR | € . | ļ | 101 | | |
| Jowel / um | | <u>ر</u> | U Y | | | | | <u>کح</u> | 11 5 | | $\times 4$ | <u> </u> | | |
| SCHOOL AND WORK EXCUSE PATIEN | IT NAME | Ē | l | | | | | | DATE | (| | | | |
| ☐ No work for days | | | | | | for | | | | | | | | |
| ☐ Light work for days | | | | | - | al Educatio | | | | days | | | | |
| ☐ May return to work on | | = | | □ Ma | ay return | to school | on. | | -/- | 7 11 | | | | |
| Wiregrass Hospital | | | Þ | HYSICIAI | N'S SIGNA | TURF / |)'./ | . 6- | ~ 1 <i>P)</i> | AL- | h. | ż | |) |

| WIREGRASS N | MED†C2 | AL CENTER | 1: | 200 W MAI | PT.TR Z | AVE. | | GENE | VA | | A: | ւ 3634 | , O | | | |
|-------------------------------|---------|----------------------|--------------------|---------------------------------------|----------|-------------|-----------------|-----------------|----------|---------------------------------------|-----------|-----------|--|---------------------------------------|------------|----------|
| WITHGRAND I | | | | | | | | | | RGFN | | 00M• | | ATIEN | JT RE | CO |
| PATIENT NUMBER | TYPE | PATIENT NAME | | | | | RTHDATE | | SEX | M/S I | DATE OF S | ERVICE | TIME | | CLERK | INIT. |
| 488763 ADDRESS - LINE 1 | 3 | NUNN JOWI | EL ADDRESS - | LINE 2 | | 27 : | 1/08/19 CITY | 977 | M | SB | 1 1 | IP CODE | 1 | LEPHON | | |
| 202 SOUTH F | BROAD | ST NOTIFY IN CASE | OF EMERGENCY | - NAME | RELAT | IONSHIP | SAM | ISON ADDRESS | | | AL | 36477 | | LEPHON | 398-9 E | 9907 |
| 422847896 | | NUNN LIN | | | | HER | T OR GROUP | SAME | | | SAMSO | N AL | 3 | 34-8 | 398-9 | 907 |
| INSURANCE COMPANY | | | | | | COMPRAC | .I OK GROOF | MOMBER | | 5/2 | 21/04 | HOM | E | | | _/ |
| | | | | | | | | | | | TIME | FEL: | L/I N J | TO | LEG | |
| GUARANTOR NAME NUNN JOWEL | | | GUARANTOR 202 S | ADDRESS OUTH BRO | AD S | r | SZ | MSON | | | AL 36 | CODE 477 | | UAR. T | 9907 | E / |
| GUARANTOR EMPLOYER SELF | | | | GUARANTOR OCC | CUPATION | N | GUAR. EN | PLOYER A | ADDRESS | | | - | GI | JAR. EMPL | TELEPHON | <u>*</u> |
| PREV. SERVICE | | V. SERV. DATE | IF MINOR - | PARENT NAME | | - | | ED. REC. | | | | NG/2ND PH | _ | | | |
| 360064 | X-RAY |)/31/98 LAB | RESP. TH. | PHY. TH. | EKG | r | .v. 4 | DRUGS | | PLIES | OTHER | HUM O | | R. RM | TOTAL I | DUE |
| CHARGES | | | AUTHORIZATI | ON FOR TREATMENT | CHARAST | THE OF PAYS | MENT ASSTC | MENT OF T | NSURANCE | RENEFITS | | | | | | |
| DATE CHIEF COMPLAIFELL/INJ TO | NT (If | TIME Accident St | ate How, | SIGNED PATIENT | | | | | SI | GNED ARANTOR | | | | | | |
| | | | | | | | | | | | | | | | | |
| TEMP. PULSE RES | iP. B/1 | PALLERGIES | | | MEDI | CATIONS - | - HOME | | | | | E.R. PE | YSICIAN | | TET. | . TOX |
| NURSES NOTES: | | L | | | | | | | | · · · · · · · · · · · · · · · · · · · | | | | | <u> </u> | |
| ***** | | | | | | | | - | | | | | | ··· | | |
| | | | | | | | | | | | | NUR | SE'S SIG | NATURE | (RN OR | LPN) |
| LAB DATA (Inc. | luding | X-Rays, EKG | s, etc.) | | | | | | | | | | ······································ | | | |
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| PHYSICIAN'S RI | EPORT . | | | | | | · | | | | | | | | | |
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| DIAGNO | 19T | D : | | | | | | | | | | - | | | | |
| REATMENT: | | | | · | -1 | | | - | | | | | | | | |
| | | · | | | | | | | | | | — т | COM | ITION | ON DISC | |
| | | | | | | | | | | | | | | STABLE | | |
| INSTRUCTIONS T | O PATIE | ent: | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | 1 | | | | | |

M.D.

Page 31 of 134

Wiregrass Medical Center 1200 W. Maple Avenue Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

to pay in full immediately.

Date

Signature

488765 Munn Jours

Relationship to Patient

- 1. MEDICAL AND SURGICAL CONSENT FOR TREATMENT: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.
- 2. RELEASE OF INFORMATION: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.
- 3. RELEASE FROM LIABILITY FOR VALUABLES: I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.
- 4. GUARANTOR AGREEMENT: The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.
- 5. ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

| THE PATIENT OR IS DU | LY AUTHORIZED BY THE PATIENT AS PATIENT' | S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS. | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|
| Date | 22- 2004 | Y Joeell S. Van | | | | | | | |
| Witness | orcy Mutn | Patient's Agent or Representative | | | | | | | |
| | | Relationship to Patient | | | | | | | |
| PA" | ASSIGNMENT OF ME TIENT CERTIFICATION, AUTHORIZATION TO R | EDICARE BENEFITS: ELEASE INFORMATION, AND PAYMENT REQUEST | | | | | | | |
| or other information about Medicare claim. I request such physician or organiza | me to release to the Social Security Administration that payment of authorized benefits be made on | XVIII of the Social Security Act is correct. I authorize any holder of medical n or its intermediaries or carriers any information needed for this or a related my behalf. I assign the benefits payable for physician services or authorize me. I understand that I am responsible for Part A deductible for each spell of e charges and any personal charges incurred." | | | | | | | |
| Date | Signature | Relationship to Patient | | | | | | | |
| | ACKNOWLEDGEMENT OF MEDICARE | | | | | | | | |
| I hereby declare I am a pa group practice. I understar | urticipant in the Medicare Program and I am not en and that if it is found that I am a participant in any of t | nrolled in a health maintenance organization, (H.M.O.), or any other pre-paid he above mentioned practices, I will be considered a self-pay patient required | | | | | | | |

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

Р

| Patie | ent Name | | NUNN, JOWEL | Discharge Dat | e | 05/22/2004 |
|---------------------|---|---------------|--|----------------|----------------|-------------|
| Adm | ission Dat | e | 05/22/2004 | Date of Birth | | 01/08/1977 |
| Med | ical Record | d Number | 422847896 | Sex | | Male |
| Age. | | | 27 | | | |
| Acco | ount Numb | er | 488763 | | | |
| <u>DX</u> 1 2 | <u>Code</u> 923.8 E819.2 <u>Code</u> | | tiple Sites of Upper Limb ent NOS Injuring Motorcyclist | Procedure Date | <u>Surgeon</u> | |
| <u>CPT</u> | Code | CPT Modifiers | CPT Description | | CPT Date | CPT Surgeor |
| | | APC PSI | Payment Rate | | ASC Group | ASC Fee |
| | | | | | | |
| Atten | iding Physi | ician | 000700 | | | |
| Cons | ulting Phys | sician | | | | |
| Disch | narge Disp | osition | 01 - Home | | | |
| DRG | = | | | | | |
| Statu | s | | | | | |
| Memo DRG | 0 | | | | | |
| MDC | | Weight | AMLOS | GMLOS | LOS | 3 |

05/25/2004

PRINT DATE: 05/23/04 902 Wiregrass Medical Center PAGE
Ed'Benak M.D. 01D0304961
Medical Director CLIA Number
TIME: 13:00 LABORATORY --- CUMULATIVE REPORT H5LACUM

 NAME:
 NUNN JOWEL
 SEX....:
 M
 PHY..:
 MITCHUM 0 D MD

 ACCT#:
 488763
 AGE....:
 27 Y
 ADMIT:
 05/22/04

 ROOM:
 E.R.
 - NO PENDING ORDERS
 DOB....:
 01/08/1977
 MR#..:
 422847896

PAT. PHONE: 3348989907

| HEMATO | OLOGY | |
|--------------|---------------|--------------------|
| | 05/22/04 | REFERENCE |
| | 1235 | RANGE UNITS |
| WBC | 9.8 | 4.3 - 11.0 K/uL |
| RBC | 4.71 | 4.60 - 6.20 M/uL |
| HEMOGLOBIN | 14.5 | 14.0 - 18.0 gm/dL |
| HEMATOCRIT | 42.8 | 38.0 - 56.0 % |
| MCV | 90.9 | 80.0 - 94.0 fL |
| MCH | 30.7 | 26.0 - 33.0 pg |
| MCHC | 33.8 | 31.0 - 36.0 gm/dL |
| PLATELETS | 223 | 150 - 375 k/uL |
| RDW | 12.1 | 10.2 - 15.5 % |
| MPV | 9 | 7 - 10 fl |
| NEUTROPHILS% | 67 | 50 - 87 % |
| LYMPHOCYTES% | 22 | 16 - 46 % |
| MONO% | 7.0 | 5.5 - 11.7 % |
| EO% | 1 | 0 - 2 % |
| BA% | 3 н | 0 - 1 % |
| NEUTROPHILS# | 6.5 | 1.5 - 7.1 K/uL |
| LYMPHS# | 2.2 | .8 - 2.8 K/uL |
| MONO# | 0.7 | .38 K/uL |
| EO# | 0.1 | .02 K/uL |
| BA# | 0.3 н | .01 K/uL |
| DIFF | NOT INDICATED | |

| | 05/22/04 | REFERENCE |
|--------------|-----------|---------------|
| _ | 1211 | RANGE UNITS |
| Clarity | Clear | Clear |
| Color | Yellow | Yellow |
| Glucose | Negative | Negative |
| Bilirubin | Negative | Negative |
| Ketones | Trace | Negative |
| Sp Gravity | >=1.030 | 1.003 - 1.030 |
| Blood | Small | Negative |
| ph | 6.0 | |
| Protein | 30 | Negative |
| Jrobilinogen | 1.0 | |
| Vitrite | Negative | Negative |
| euk Esterase | Negative | Negative |
| ICROSCOPIC | SEE BELOW | |
| lbc . | RARE | None Seen |
| bc | 4-6 | None Seen |

PRINT: 05/23/04 13:00 **NUNN JOWEL** 902 Page: 1 LAST

1200 WEST MAPLE AVENUE GENEVA, ALABAMA

RADIOLOGY REPORT

NAME: NUNN JOWEL **AGE**: 27 **SEX**: M DOB: 01/08/1977

STAY TYPE: E.R. ROOM: **ADMIT DATE**: 05/22/04 ACCT NUMBER: 488763

LOCATION:

TRANS DATE: 5/24/04

PATIENT PHONE: 334/898/9907 ORDERING PHY: MITCHUM O ADMITTING PHY: MITCHUM O

REFERRING PHY: **FAMILY PHY:**

XRAY NUMBER: 2604 MR NUMBER: 422847896 TRANS INITIALS: SR

<=X-RAY ORDER=>

COMPLETE:05/22/04 12:27 SAD 76956

Reason for Procedure: INJURY

SHOULDER MIN 2V

73030 COMPLETE:05/22/04 12:27 SAD 76957

*** UNSIGNED TRANSCRIPTIONS REPRESENT A PRELIMINARY REPORT AND DOES ****** NOT REFLECT A MEDICAL OR LEGAL DOCUMENT ***

LEFT SHOULDER AND SCAPULA 2 VIEWS: THE AC JOINT IS INTACT. THERE IS NO DEFINITE FRACTURE OR DISLOCATION IDENTIFIED.

OPINION: UNREMARKABLE EXAM.

JOHN C. TOMBERLIN, M.D.

Jowel Dann 1/8/11

| UNN JOWEL E.R. Wiregrass Med | lical Center |
|---|---|
| ER Medica | Record () Emergent () Urgent () Non-Emerge |
| Triage Motes: Was unvolved in note | cyple acident yester Time: 1140 |
| lower almosign lett wageram | and let shoulder Pemp: 9880 |
| homatoma let side of hood C/D | Tel: De Williams Pulse: 80 |
| Allergies: NKA | LMP: SpO2: 982 Resp: 20 |
| Meds: None | BP: 143/151 |
| Mades. | Nurse Signature: Debra Cuch |
| H&P and CC: | РМН: |
| 17 | |
| HPI: Morre | Surg: |
| /~ · | |
| · | Social/Habits: |
| / | 2 11 selle |
| General: Orge Sorrow | W Family Hx; |
| HEENT Gran burn | Tudu. |
| Neuro: | ROS Neg Document if positive |
| Heart: | Neuro/Psych: |
| Lungs: | Cardio/Resp: |
| Musculoskeletal: | gul, GU: |
| Abd/Rectal: | Other: |
| GU/Gyn: | 1,1, |
| Ext/Skin: | 40 |
| Dx: , (VG) | |
| Physician's Orders: CBC BMP/CMP | / Medication Ini |
| EKG() ABG() PT/PTT() | |
| UA(Rout)(Cath) (CT() Amylase | () |
| CXR(X) Listuidies (US()) | |
| CM() O2() Foley() IV: | |
| Disposition: Home(X) Dr. Office() Surgery() Expired() Adm | Rm# AMA/LWBS() Date/Time: 5/22/84 315 |
| Transfer to C/O Dr. | Via |
| Condition at Discharge/Transfer: Improved() Stable | Deteriorated() Unchanged() |
| Instructions to Pt: (1) Rx: | |
| (2) Instructions: | |
| (3) Follow up: | |
| Signing this form denotes that I have reviewed all information on this do | cument and I agree: |
| Physician's Signature: | Family Dr. 1512 |

| · | | | | | | A104 |
|--|--|------------------------|---------------------------------------|-------------------------------|---------------------------------|---|
| HUROMAKA | t: 🗆 Yes 🗆 No | Sensation Intac | t unable to rate | d 🗆 🔻 | E N | Kelieved By: |
| | Warrn Cold | Temp:\ |] | | | Exacerabated By: |
| | Brisk 🗆 Slow | Cap. Refill: | l | 0ĭ 6 8 <i>L</i> | 9 (3) 4 (2) 6 | 0 1 |
| Comments: | | Pulse: | | | | Зечепіту: |
| | ON 🗆 Yes | Full ROM: | | | | |
| someone? Yes No | A Prince Control of the Control of t | Ext Deformity: | (900 | Radiation (arrow ab | | Comments: |
| If no, would you like to talk to | ~ ~ ~ ~ ~ | 5 4 7 4 | | | | |
| living environment? □ Yes □ No | ar Handi | TPYOTE SEASON. | (9ve | Location (circled ab | dA | Grav Para |
| Do you feel safe in your present | | Sensation Intact | _AA | AA | | □ Scant □ Mod |
| tassera zuen di etes leet neur eff | и 🗆 х 🗆 🗆 | Pulse: (| | 717 | | Vaginal Discharg |
| □ Combative □ Anxious | N□Y□ noitol | Full Range of M | /// | <i>/</i> | □ Xes □ No | Vaginal Bleeding |
| Deformative Disoriented | | / : | (1) | (X .) | □ Yes □ No | Bleeding: |
| Affect: Momal Flat | | Comments: | 1-11-1 |) V (| ON 🗆 89Y 🗓 | Frequency |
| Eye Contact | olled: 🗖 Yes 🗖 No | Bleeding Contro | | / *\ | O Y CO NO | Rain in Voiding: |
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| Slurred Speech? Zes Tho | | Location(s): | W W | \\ \\\ | | Comments: |
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| MegK □ □ 2#cong □ □ | | GCS Total (3-1 | 7,7 | 5 | ☐ LBM: ☐ Present | ☐ Constipation Bowel Sounds: |
| Hand Grasp: L R | chensible Sounds 2 No Response 1 | ndinosia. | \cup | (A) | □ Diarrhea | gnitimo√ □ |
| vratrulovnl 🗆 | S sbrow 3 Stroprops S S S S S S S S S S S S S S S S S S S | | morawa o = | funfur myn r | □ Nausea | □ Distended |
| Movement: Voluntary | 4 səsrəvno Vbətnər | Verbal Disor | noite20,] | Yaulal\aisq | ि हर्ने च इड्डायमम | 0047 |
| Visual Acuity: OD: OS: | Səsrəvno Əlbətnə i | | | | | |
| Size: L: R: Visual Acmity: $\square N \land A$ | No Response 1 | | | Comments: | | Comments: |
| Monreactive □L □R | Extension 2 (Kigidity) | (Decerebra | Quick = 510W | Capillary Refill: 🛭 | 0N 2 3 S | Dyspnea? □ Yes |
| Sluggish 🗆 L 🗆 R | te Rigidity) | (Десоціся | | | ons?□Yes ⊡ No | |
| Pupils: Brisk 🗆 L 🗆 R | S lamondA\noixsl | H. | | JVD: Yes GY | ovitouborquotive □ | |
| □ Inappropriate Response | 4 lewerbdriw-noix | | _ | Edema: 🗆 Yes 🖭 | Productive | |
| Orientation: | ObeysO Cocalizes Pain Cocalizes Pain | Best Motor Response | Flushed Pale | ☐ Cyanotic | ☐ Bil. Clear ?ales ☐ Wheezes | Breath Sounds: |
| ☐ Unresponsive ☐ Lethargic | No Response 1 | Post Motor | □ Pink | Color: T Normal | □ Deep | i i |
| ☐ Responds to Pain | 2 nisq oT | | 🗖 Сјуших | D C919 | wollsa∏ | |
| PAlert □ Responds to Voice | Verbal Command 3 | OT | □ Diaphoretic | Hot □ | □ Irregular | |
| Level of Consciousness: | Spontaneously | Eles Open: | ALC PO | Skin: 🖸 Warm | TKegular | Respirations: |
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O2/SS/O4 DOB-O1/O8/11 S1 WALE 488763 HITCHUN O D ND NUNN JOWEL

WIREGRASS MEDICAL CENTER 1200 W. MAPLE AVE.

ED-OP **HOME INSTRUCTION SHEET**

| GENEVA, AL 36 | | | 1. MEDICAL | RECORD NO. | 12 | 2. BILLING NO. | | 3. A/R NO. | | | | |
|--|---|--|-------------------------|---------------------|--|--|---|----------------------------------|---|--|--|--|
| (334) 684-365 | | | | | | | ļ | | | | | |
| This program of the control of the c | | | 4 6/100 | Te aver | | | MATION | | | | | |
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| | SEX 12. RACE 13. BIRTHDATE | 14. A | GE | 15. HEIGHT | 16. WEIGHT | 17. SS | 18. MS 19. | _ ! | | | | |
| NUNN JOWEL | E,R. | | | | 1 | | | | | | | |
| 20. RP 21. NOTIFY IN EMERGENCY TO TO THE TOTAL OF THE TOT | 22. HOME TELE | 23. WORK TELE | | 24. HOW PATIENT ARR | RIVED | | | | | | | |
| DOB-01/08/77 27 HAI | , t | | | | | | | | | | | |
| 25. C COMPLANT 26: 1 2 2 1 0 4 | | | 0 | UTPATIENT | SURG | ERY INFOR | RMATION | | | | | |
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| SPRAIN, FRACTURE, & SEVERE BRUISES | BACK AND NECI | K INJURY IN | STRUC | TIONS | T | HEA | D INJURY I | NSTRUCT | IONS | | | |
| ☐ Elevate the injured part above level of heart to lessen swelling. If pillow: | S USE HEAT OR COLD ON THE | E IN HIDED ADEA | uhiahau | 40 hala | | | | | | | | |
| flatten, use chair cushions with pillows or blanket for comfort. | the most. Be careful not to | | - William | ver seems to neip | | s wno receive bid by X-ray or exai | ows to the head mination soon a | l may have inj fter accident. | juries that cannot always For the next 24 hours it | | | |
| Ice packs also help prevent swelling, especially during the first 48 hours. | Rest as much as possible unt | til you are improv | ed. | | | rtant that these | | | | | | |
| Place ice in plastic or rubber bag, cloth covering; after 48 hours, use hea | 11 | | | | whe | ere he is and is n | ot confused. | _ | ght, to be sure he knows | | | |
| If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M. | | | | | Che | ck eyes to see ti rent the taking o | hat both pupils f sleening nills | are of equal s | iize. or alcobol | | | |
| ☐ If you have a cast, keep it perfectly dry at all times. | Gentle but firm massage will helps to clear the soreness. | increase circulat | ion in sore | muscles and | ☐ Res | trict excessive w | ork or play. | | | | | |
| ☐ Wiggle toes or fingers to help prevent swelling in the cast—this should be | Wear special collar when out | of bed. | | | □ Devi | <i>your family doct</i> elops a severe he | <i>tor or local hosp</i> eadache. | oital immediati | ely if the patient: | | | |
| done often if it does not cause pain. ☐ If the part swells anyway or gets cold, blue or numb or pain increases | | | | | U Vom | its more than tw Infused, faints o | rice within a sh | ort time. | | | | |
| markedly, have it checked promptly. | | | | | ☐ Has | a pupil of one ey | e larger that th | ne other | | | | |
| ☐ Use crutches. | | | | | ☐ Com | plains of double vs abnormal beh | vision avior such as s | taggering or v | walking into things. | | | |
| X-RAY INSTRUCTIONS | WOUND CARE (Cuts | Ahrasions | Rurne | Stitchee) | #== | | | | | | | |
| | ! | | Duillo, | outeries, | 11 | V | & DNITING | DIAKKHE | А | | | |
| Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning | Keep the dressings clean and Elevate the wound to help relie | • | hain enaar | t wound haaling | 11 | ot feed anything | | | • | | | |
| by Radiology Dept. If any abnormalities are found that have not been called | Despite the greatest care, any | | | | | | | | ea, offer 2 tablespoons oke, Gingerale, 7-up, | | | |
| to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be | becomes red, swollen, shows p of less sore as days go by, you | ous or red streaks | , or feels r | nore sore instead | weal | tea, Gatorade d | r Jello, water. | If patient is I | hungrey you may add 1 | | | |
| reached.) Sometimes fractures or abnormalities may not show up on X-rays | Dressing should be changed in | | | ur rigiit away. | 11 | oon of sugar to ER NO CIRCUMS | | • | PRODUCTS | | | |
| for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, | ☐ Treatment rendered | | •• | | и | | | | our. If after 4 hours no | | | |
| come by the hospital and pick up your X-ray and take them with you to the | ☐ Tetanus Toxiod given | | | | vomiting has occured, the amount may be slowly increased. | | | | | | | |
| doctor's office. Please call ahead to X-ray Dept. | 250 units of tetanus immune g immunization, you must receive | plobulin was giver e two additional r | ı. To com loses of t | oxoid 4-6 | Using no more than ½ glass (4 ounces) of liquid at a time continue treatment for 24 hours. | | | | | | | |
| | weeks apart. Call your physici | ian for the next d | ose. | | 11 | | | er instruction | s after 24 hours. | | | |
| · · | Warm soaks to area 4 times da Continuous warm compresses. | aily. 20-40 minut | es each ti | ime. | | | | | | | | |
| | | | | | | | | | | | | |
| GENERAL INSTRUCTIONS | FEVER | ROVER 102 | | | | AN | IMAL OBSE | RVATION | 1 | | | |
| 🔲 Stay in bed/may go to bathroom. | Sponge with lukewarm water in | n the tub. | | ĺ | Instruction | ns for observatio | for observation of any animal that may have bitten a human if | | | | | |
| ☐ Use vaporizor. | If temperature increases or pers | sists for 24 hour | s, see you | r family doctor. | | al is available for | | | · | | | |
| ☐ Drink large amounts of liquids. ☐ Take aspirin every 4 hours | | | | | | animal taken to \ | | | e Vetennarian, notify | | | |
| Avoid any use of injured part. | | | | | | unty Health Offi | | | s vetennarian, notity | | | |
| ☐ Allow only limited use of the part. | EYE | INJURY | | | | | | | | | | |
| ☐ You need not necessarily limit activity. | Any eye injury is potentially haz | ardaue | | | | | | | 1 | | | |
| Fill Prescriptions given to you from Emergency Dept. and take as directed. | ☐ Any increasingly severe discomf | | udden imn | airment of | | | | | I | | | |
| No driving or any activity requiring mental alertness after receiving | vision should be reported immed | | | | | | | | | | | |
| medication. | below. Do not drive with eye patch. | | | ij | | | | | I | | | |
| | | | 4.0 | | | Ta 1 | | | | | | |
| ADDITIONAL INSTRUCTIONS | | | | nost | 201 | Wals. | Sho | mel | DO dout | | | |
| apply onlikisted in | tment a | | | | 786 | | <u></u> | | | | | |
| I hereby acknowledge receipt of all the inst | | | | | | | | | | | | |
| may be released before al my medical probl my conditions worsen or new symptoms a | | | | | o care a | s indicated | above. 11 | understar | nd that if | | | |
| | URSE'S SIGNATURE_ | | | • | HYSICIA | N'S SIGNA | TURE | | | | | |
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| WIREGRASS MEDICAL CENT | EK PHYSICIA | AN'S SIGNA | TURE | | | | | | [| | | |

ADVANCE DIRECTIVE

ACKNOWLEDGEMENT

| NAME: DUM. | Jan 0 | soc. sec. no: <u>42</u> 2 - 84 - 4896 |
|--------------------|--------|---------------------------------------|
| IDENTIFICATION NO: | 488763 | DATE OF BIRTH: 1-8-1977 |

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

- 1. I have been given written materials about my right to accept or refuse medical treatments
- 2. I have been informed of my rights to formulate Advance Directives.
- 3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.
- 4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ I HAVE executed an Advance Directive.

Signed Soul S Date: 5-2204

Witness: Date: 5-20-04

Witness: Date: 5-20-04

Wiregrass Medical Center
ER Level of Service Charge Sheet
Integumentary

| | | | Integumentary | 7.8 | |
|------------------------------------|--|--------------|--|----------|----------|
| | E.R. | | Repair of Nail Bed | 1961176 | 30 |
| 488763 MITCHUM O D ND | | | Subungal Hematoma | 1961174 | 40 |
| DOB-01/08/77 27 MALE | | | Dressing Application | | |
| 05/22/04 | | | FB removal | 1961012 | 20 |
| | | | I&D Abcess | 1962000 | 0 |
| ER/ROOM | | | Laceration Repair (simple,intermed) | 1960000 | 00 |
| Circulatory + - | | | Laceration Complex | 1961000 | 10 |
| Jugular,Cutdown, Central Line | | A. | Debridement | 1961104 | 0 |
| Blood Administration | 19636 | 430 | Treatment of Burns | 1961602 | .0 |
| Cardioversion, Mechanical | 19692 | 960 | Orthopedics | | |
| Code Blue | 19692 | 950 | Behr Block/Regional Block | | |
| External Pacemaking | 19692 | 953 | Casting/Splinting | 19629500 | 0 |
| Intubation | 19631 | 500 | Removal or Revision of Cast | 19629705 | 5 |
| Immunization (Td, Hepatitis B) | | | Tx of fx/dislocation with manipulation | | |
| Immunization (Rabies) | 19690 | 675 | Compartmental Syndrome | 19620950 | 5 |
| Medication Administration IV | 19690 | 784 | Neurological | | |
| Medication Administration IM or SC | 196907 | 782 | Lumbar Puncture | 19662290 |) |
| Paracentesis | 196490 | 080 | | | |
| Peritoneal Lavage/Tap | | | | | |
| Thoracentesis | 196320 | 000 | | | |
| Pericardiocentesis | 196330 | 10 | | | |
| Chest Tube Insertion | 196320 | | | | |
| IV Hydration | | | | | _ |
| CPR | | | | | |
| FILE ENTRY | | | | | |
| Eye Irrigation | | | | | _ |
| Eye Exam/Corneal Abrasion | | | | | |
| Foreign Body Removal Ear | | | | | |
| Foreign Body Removal Nose | | \dashv | | | |
| Irrigation Ear | | +- | | | |
| Nose Bleed/Nasal Packing | 1 | - | | | \neg |
| Rust Ring (Foreign Body Removal) | | + | Treatment Level | | |
| Respiratory | | | | 19699281 | |
| Tracheotomy | 1963160 | 3 | | 9699282 | \neg |
| Cricothyrotomy | 1963160 | | Emergency I with procedure | | \neg |
| Trach Change | 19631603 | | | 9699283 | |
| Gastrointestinal | | | Emergency II with procedure | - | \neg |
| Gastric Lavage or NGT insertion | 19691105 | 5 | | 9699284 | \dashv |
| Gastrostomy Tube Placement | 19643760 | | Emergency III with procedure | | \neg |
| Genitourinary | 10,00 | 351 | | 9699285 | \dashv |
| Delivery/Birth | 19659409 | | Emergency IV with procedure | | \dashv |
| Supra Pubic Cath, or Turkey Tray | | | | 9699291 | \dashv |
| Irrigation of Catheter | 19651700 | | Critical Care with procedure | | \dashv |
| Pelvic Exam | | | Observation I | | \dashv |
| | | | Observation II | | \dashv |
| | | | C D C C I T C L C C I I I | | 1 |

Observation III

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Wiregrass Medical Center

| | a tanking medici | فالقديد | | | Lykeland - d | V V | | grass Medical Center nergency Physician's Cha | rao F | hact | Date: ' | |
|----------|------------------|---|--|-------------|---------------|--|---------------|---|--------------|---------------------------------------|-------------------------------------|-----------|
| | | | , | j | 10,27 | | | Debridement | | | Date: | |
| | | | | | S. | | | Infected Skin | | | e, Ears, Eyelids, Nose, Lips, | |
| | МОГ ИИ | | E.F | ₹. | | + | | Partial Skin Thickness | - | | nd/or Mucous Membranes | |
| | | | HUN O D ND | | | | | Skin, Full Thickness | | | 011 2.5 cm or less | |
| | | 8/1 | 77 27 MALE | - 1 | | | | Skin and Sub Q Tissue | - | | 013 2.6 - 5.0 cm | |
| 05 | /22/04 | | | | : | 195110 | 043 | Skin, Sub Q, Muscle | \top | 195 | 214 5.1-7.5 cm | |
| r p | /ROOM | | | | 8 | 195110 | 044 | Skin, Sub Q, Muscle, Bone | | - - | 115 7.6 - 12.5 cm | |
| L 11 | | 745 | Level of Service | | | | He | ematoma and Abcess | | 195120 | 16 12.6 - 20.0 cm | |
| | 1959 | 99281 | Level I | | | 195100 | 060 | I&D Simple Abcess, Furuncle | | 195120 | 17 20.1 - 30.0 cm | |
| | I | | Level II | | | 195100 | 061 | I&D Simple Abcess, Complicated/ | | 195120 | 18 Over 30.0 cm | |
| | | | Cevel III | | | | | Multiple | | 195120 | 20 Superficial WD Dehis | |
| | | | Level IV | | | | $\overline{}$ | I&D Hematoma Simple | | 195120 | 21 Superficial WD Dehis-Pack | |
| | | | Level V | | | | | I&D Puncture Aspiration, Abcess | | Rep | air/Intermediate-Layered. | |
| | | | Direct Life Support In Transit | | | | | Hemorrhoid, Thrombosed | | Scalp, A | killae, Trunk, and/or Extremities | |
| | | | Visit with Surgery | | | | | Burns | | 195120 | 31 2.5 cm or less | |
| | | | Critical Care per Hour | | | | _ | First Degree Burn, Initial | | 195120 | 32 2.6 - 7.5 cm | |
| - | | | Critical Care per 1/2 hour | | | | \rightarrow | Small Burn, Debride, Dress | | 1951203 | 34 7.6 - 12.5 cm | |
| - | | | NG Lavage/Aspiration | | | | - | Medium Burn, Debride/Dress | \bot | 1951203 | 35 12.6 - 20.0 cm | |
| F | 19599 | - | Ipecac Admin/Observe Gastric | | | | | arge Burn, Debride/Dress | | | 6 20.1 - 30.0 cm | |
| | | COLUMN TO SERVICE STATE OF THE PARTY OF THE | emptying. | | $\overline{}$ | | | B/GYN-Procedures | | 1951203 | 7 Over 30.0 cm | |
| | 10534 | | irway/Pulmonary Endotracheal Intubation | | | | | &D, Abcess, Vulva | | | , Feet, and/or External Genitalia | <u>a</u> |
| - | | | B Removal | | | | -+- | &D, Bartholin Abcess | | | 1 2.5 cm or less | |
| H | | | Tube Thoracostomy | | 25.00 | Contract of the Contract of th | ******** | mergency Vaginal Delivery | | | 2 2.6 - 7.5 cm | |
| | | and the same of | cular Procedures | | | | 1 | Arthrocentesis | - | | 4 7.6- 12.5 cm | |
| | | | lon-Routine Venipuncture | | | | _ | rthrocentesis, Small Joint rthrocentesis, Intermediate Joint | | | 5 12.6 - 20.0 cm | |
| \vdash | | | V Therapy Requiring MD | | | | | rthrocentesis, Intermediate Joint | | | 20.0 - 30.0 cm | |
| - | 10000 | | er hour | | | | | ellaneous Fractures | | | Over 30.0 cm | |
| F | 195929 | | hrombolysis IV infusion | | | | | osed Rib Fracture | | | Ears, Eyelids, Nose, Lips, | |
| h | | | diac Procedures | 1 | | 9523500 | + | · · · · · · · · · · · · · · · · · · · | | | or Mucous Membranes 2.5 cm or less | |
| | 195929 | | | | \top | , | , | | + | | 2.6 - 5.0 cm | |
| | 195929 | 53 Tı | ranscutaneous Pacing | _ | 19 | 9526750 | Cic | osed Distal Phalangeal | 1- | | 5.1 - 7.5 cm | |
| | 195929 | 30 C | ardioversion, Elective | 1 | | | + | osed Fracture, Great Toe | | | 7.6 - 12.5 cm | |
| 2.6 | | Ċ | pthamology | | | | + | osed Phalanx other than Gr. Toe | | | 12.6 - 20.0 cm | |
| | 195652 | 05 FE | 3 | | | Miscella | inec | ous Closed Dislocations | | 19512056 | 20.1 - 30.0 cm | |
| | 195652 | 10 FE | 3 Conjunctival/Embedded | | 19 | 521480 | ТМ | IJ Uncomplicated | | 19512057 | Over 30.0 cm | |
| | 1956793 | | | | 19 | 523650 | Sho | oulder w/ Manipulation | | Repair/Co | mplex-Reconstructive or | |
| | | Ear,N | ose, and Throat | | 19 | 524640 | Nur | rsemaid's Elbow | ** | Compl | icated Wound Closure | |
| _ | | | Pharynx | <u> </u> | 19 | 526700 | Fing | ger, MP Joint | | | Trunk | |
| - | | | External Ear Canal | | | | | ger, IP Joint | | | 1.1 - 2.5 cm | |
| - | | + | pacted Cerumen | | | | | IP Joint | | · · · · · · · · · · · · · · · · · · · | 2.6 - 7.5 cm | _ |
| - | | | Intranasal | | T T | | | meous Procedures | | | o, Arms, and/or Legs | \exists |
| - | | | erior Epitaxis, Simple | ├ | | | | e Catheterization, Simple | | | 1.1 - 2.5 cm | $ \bot $ |
| - | | 1 | erior Epitaxis, Complex | | | | | e Catheterization, Complex | | 19513121 | | \dashv |
| | | | terior Epitaxis, Initial | | | | - | al Puncture | | | heeks, Chin, Mouth, Neck, | 4 |
| | | - | oreign Body Removal Q, Simple | | | 64450 | | | | | nitalia, Hands, and or Feet | 4 |
| \vdash | | + | Q, Complicated | | | | | I for Occult Blood | | 19513132 1 | | 4 |
| - | | - | cle, Simple | | | | | hm Strip Interpretation | | | Nose, Ears, and/or Lips | - |
| | | + | | | | | | mple-Single-Layer | | 19513151 1 | | \dashv |
| | | | Nails. | ocaip, | , INEC | | | external Genitalia, Trunk, remities | - | 19513152 2 | 0 - 7.3 CIII | - |
| | | | sion/Nail, Simple | $\neg \tau$ | 1951 | | | n or less | + | | | \dashv |
| | | | ngal Hematoma | -+ | | 2002 2.0 | | | + | | • | + |
| | | | | | | 2004 7.6 | | | _ | | | 1 |
| | | | | | | | | 20.0 cm | + | | | 1 |
| | | | | | | 2006 20. | | | - | | | 1 |
| | 1 | | | | | 2007 0 | | | | | | 1 |
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1200 W MAPLE AVE

GENEVA

AL 36340

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|--|--|---|--|--|---|--|--|--------------------------|------------------------------------|---|--------------------------|--|--|--|--|---|
| PATIENT NUMBER 488813 | 3 | | TIENT NAME UNN JOW. | | | | | | 1977 | SEX M | SB I | 5/2 | SERVICE 3/04 | 21 | .:45 | DWP |
| ADDRESS - LINE 1 202 SOUTH | | | | | - LINE 2 | | | Si | MSON | | | STATE AL | 36477 | | | 898-9907 |
| PATIENT SSAN 422847896 | | - 1 | TIFY IN CASE UNN LIN | | | 1 | HER | | SAME | 1 | , | SAMS | IA NO | | 334- | E 898-9907 |
| INSURANCE COMPAN | Y | • | | | | | CONTRACT | OR GRO | OUP NUMBER | | | DATE TIME | PLAC | | | |
| | | | ·· | | | | | | | | | | | | T | |
| guarantor name NUNN JOWEI | | | | | OR ADDRESS SOUTH BRO | AD S | T | | SAMSON | | - 1 | AL 3 | 6477 | | 898- | 9907 |
| GUARANTOR EMPLOYS SELF | ER | | | | GUARANTOR OC | CCUPATIO | N | GUAR. | EMPLOYER | ADDRESS | | | | | GUAR. EMP | L TELEPHONE |
| PREV. SERVICE 488763 | F | | ERV. DATE 2/04 | IF MINOR - | PARENT NAME | | | | MED. REC. 42284 | | | | CHUM (| | N. | |
| CHARGES | X-R | AY | LAB | RESP. TH. | PHY. TH. | EKG | r. | v. | DRUGS | SUPP | LIES | OTHE | M. | D. | E.R. RM | TOTAL DUE |
| 1. The undersigned employees of the employees of the beat side as 2. The description of the employees of the beat side as 2. The description of the employees o | agrees to p gm any hosp orize the ". troller" of e said hosp | ay for ser ital bener Administra Hospital ital. | rvices rendered befiles, sick benefile ator of Hospital as my lawful att | eatment consider anted for such t y Hospital upon ts, injury benef to furnish from orney to endorse | rion for treatment ed necessary for the reatment and procedure release of patient. its due to a liability its records any infoi for me any checks may SIGNED PATIENT When, and | above named es. The und y of a Thir rmation req de payable | patient, and t ersigned has re d party, payabl uested by the b to me for benef | that treat ead the ab | ment and proced ove authorizati | dures will ion and und above pati- e companie under the | be perform erstands t | ned by physiche same and ospital unlection with gramment and | sicians, memb dd certifies ess I pay th the above as to apply an | ers of hous chat no gua e account i signment. | e staff and rantee or ass n full upon n I do hereby lance to any | surance release of patient. other |
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| TEMP. PULSE R | ESP. | B/P | ALLERGIES | | | MEDI | CATIONS - | HOME | | | * | | E.R. | PHYSICI | AN | TET. TOX. |
| PHYSICIAN'S | REPORT | | | | | | | | | | | | | | | |
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| DIAGN | os: | [S | • | | | | | | | - | | | | | | |
| TREATMENT: | TO PAT | 'IENT | : | | | | | | | | | | | IMP | ONDITION STABLE | |
| <u> </u> | | | | | | | | | | | | | | | | |
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| | | | | | | | | | | | | | | | | M.D. |

E.R.

NUNN JOWEL | 88813 MITCHUM O D ND | 107-01/08/77 27 MALE | 05/23/04

05/23/0

R/R00#

Wiregrass Medical Center 1200 W. Maple Avenue Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

- 1. MEDICAL AND SURGICAL CONSENT FOR TREATMENT: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.
- 2. RELEASE OF INFORMATION: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.
- 3. RELEASE FROM LIABILITY FOR VALUABLES: I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.
- 4. GUARANTOR AGREEMENT: The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.
- 5. ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

| THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENTS | GENETIAL TO EXCESSE THE STATE OF THE STATE O | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| Date | (Jaevel Sal | | | | | | | |
| Date | Patient | | | | | | | |
| - G- B- D | | | | | | | | |
| Witness | Patient's Agent or Representative | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | Relationship to Patient | | | | | | | |
| · | | | | | | | | |
| | NCADE DEMESTS. | | | | | | | |

ASSIGNMENT OF MEDICARE BENEFITS: PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

| Date | Signature | Helationship to Patient |
|------|-----------|-------------------------|
| | | |

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

| - | |
|------|--|
| Data | |

Signature

Relationship to Patient

Billing Form

For Financial Class:

Р

| Patie | ent Name | | | NUNN, JOWEL | | Discharge Dat | e | 05/23/2004 |
|-------------|-----------------|--------------|---|---|---|----------------|-----------|-------------|
| Adm | nission Date | 9 | | 05/23/2004 | | Date of Birth | | 01/08/1977 |
| Med | lical Record | Number | • | 422847896 | | Sex | | Male |
| Age. | | | | 27 | | | | |
| Acco | ount Numbe | ər | | 488813 | | | | |
| | | | | | | | | |
| DX | Code | DX Descript | | | | | | |
| 1 | 922.1 E819.2 | Contusion of | | st Wall nt NOS Injuring Motorcyclist | | | | |
| 2 | ⊏019.∠ | WW Traffic A | cciue | int NOS injuning Motorcyclist | | | | |
| PR | Code | PR Descript | ion | | F | Procedure Date | Surgeon | |
| | | | | | _ | | | |
| | | | | | | | | |
| <u>CPT</u> | Code | CPT Modifie | <u>rs</u> | CPT Description | * | | CPT Date | CPT Surgeon |
| | | APC PS | <u>I</u> | Payment Rate | | | ASC Group | ASC Fee |
| | | | | | | | | |
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| Atten | ding Physic | cian | | 000700 | | | | , |
| Cons | ulting Phys | ician | | | | | | |
| | | sition | | | | | | |
| DRG | | | | | | | | |
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| Memo DRG | o | | | | | | | |
| MDC | | Weigh | t | AMLOS | | GMLOS | LO | S |

1200 WEST MAPLE AVENUE GENEVA, ALABAMA

RADIOLOGY REPORT

NAME: NUNN JOWEL AGE: 27 SEX: M DOB: 01/08/1977

STAY TYPE: E.R. ROOM: ADMIT DATE: 05/23/04 ACCT NUMBER: 488813

LOCATION:

TRANS DATE: 5/24/04

PATIENT PHONE: 334/898/9907 ORDERING PHY: MITCHUM O ADMITTING PHY: MITCHUM O

REFERRING PHY: FAMILY PHY:

XRAY NUMBER: 2604 MR NUMBER: 422847896 TRANS INITIALS: SER

<=X-RAY ORDER=>

COMPLETE:05/23/04 21:52 SAD 77007

Reason for Procedure: MVA

RIBS UNILATERAL 2V

71100

COMPLETE:05/23/04 21:52 SAD 77008

*** UNSIGNED TRANSCRIPTIONS REPRESENT A PRELIMINARY REPORT AND DOES ****** NOT REFLECT A MEDICAL OR LEGAL DOCUMENT ***

LEFT RIB DETAIL: THE RIBS ARE INTACT. THERE IS NO DEFINITE FRACTURE OR OTHER ABNORMALITY NOTED.

OPINION: UNREMARKABLE EXAM.

| Triage Notes PON CO (MILL NOS UNIL DEPART (M. Time: 2150) BILLED (M. MOROUGH (M. M. DEPART (M. Time: 2150)) Allergies: OND LMP: Sp02: 968 Resp: 24 Medis: (M. H. MOR CS: PMH: H&P and CC: PMH: HPI: Surg: Social/Habits: General: Family Hx: HEENT Neuro: PASTON NOW PROS Neg Document if positive Heart: Lungs: Now Paston Cardio Resp: When the positive Heart: Surg: Musculoskeletal: Abd/Rectal: GU: Abd/Rectal: GU: Abd/Rectal: CBC() BMP/CMP Medication Ini EKG() ABG() PT/PTT() JA(Kout)(Cath) CT() Amylase() | | | | | | | |
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| Triage Notes. V | 11 CO (f | Malaca de | Inpo ur | 201 DIE | othing_ | | |
| 301 700 11 | 20pt - 1 | <u> INDICTUO</u> | e uccirio | UZ | aup_ | | <u> 40-</u> |
| a(10. | | | | | | | 9/1 |
| Allergies: 4)KJ | <u> </u> | | LM | <u>/P:</u> | SpO2: 486. | | 14 |
| Meds: atlac | itics, (pa | a 0115? | | ··· | - 0 | 7 | |
| | · I | | | Nurse Signa | ture: NeH | 15 (Km | <u> </u> |
| H&P and CC: | | | | РМН | : | | |
| Triage Roles NITCHUM 0 D M D Sy 23/04 Addressograph ER Medical Record Emergent Urgent (Non-Emergent Sy 23/04 Addressograph ER Medical Record Emergent Urgent (Non-Emergent Sy 23/04 Addressograph ER Medical Record Emergent Urgent (Non-Emergent Sy 23/04 Addressograph ER Medical Record Emergent Urgent (Non-Emergent Sy 23/04 Addressograph ER Medical Record Emergent Urgent (Non-Emergent Sy 23/04 Addressograph ER Medical Record Emergent Urgent (Non-Emergent Sy 23/04 Addressograph ER Medical Record Emergent Urgent (Non-Emergent Sy 23/04 Addressograph ER Medical Record Emergent Urgent (Non-Emergent Sy 23/04 Addressograph ER Medical Record Emergent Urgent (Non-Emergent Sy 23/04 Addressograph ER Medical Record Emergent Extra Record E | | | | | | | |
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| | - Juni | | 10 (| 1 | y IIA. | | |
| | Dha | nous ha | estini | ROS | Neg | Documei | nt if positive |
| | 1 Dice | 1000 | | | | | Tin posici. |
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| | X Va | 1 5, | Lee " | | West. L. | | |
| Social Habits Surg: Social Habits Surg: Social Habits Surg: Surg | | | | | | | |
| Triage Redick O D H D Wiregrass Medical Center ER Medical Record Emergent () Urgent () Non-Emerger Content Con | | | | | | | |
| GU/Gyn: | | | 1 // | | | | : |
| Triage Notice 10 0 1 1 1 1 1 1 1 1 | | | | | | | |
| Dx: | | | | | | | |
| Physician's Orders: | CBC() | BMP/CMP | / | Medic | ation | | Ini |
| EKG() | ABG() | PT/PTT() | V | | | | |
| UA(Rout)(Cath) | CT(|) | Amylase() | | | | |
| CXR() | Other Studies | L)nibs | US() | | | | |
| CM() | O2() | Foley() | IV: | | | | |
| Control Cont | | | | | | | |
| Fransfer to | Social/Habits: Soci | | | | | | |
| Condition at Discharge | Section Sect | | | | | | |
| instructions to Pt: (1) | Rx: | | | | | | |
| Social/Habits: Soci | | | | | | | |
| 3) Follow up: | | | | | | | |
| Signing this form denote | es that I have review | wed all information of | on this document ar | nd I agree: | | | |
| Physician's Signature | | | | | Family D | r (() | O(0) |

| Case 1:06-cv-00 | 452-MEF-CSC | Document | 13-6 FII6 | ed 08/07/2006 | Page 63 d | |
|--|--|--|---|---|--|---|
| Diving environments: Comments: Comme | The Test 100 1 | Response (Decerei (D | MGo | Cyanotic Edema: Yes JVD: Yes Capillary Refill: Comments: Pain/Injury Location (circled and and and and and and and and and an | Shallow Shallow Shallow Shales Wonproductive Productive Productive Productive Productive Productive Present Present | Breath Sounds: |
| ☐ Alert ☐ Responds to Voice | S Verbal Command 5 Verbal Command of S | I. | ☐ Diaphoretic | 10 H Ot | Irregular | 1 |
| Level of Consciousness: | Spontaneousky 4 | Exes Open: | A DIA | Skin: Warm | Regular | Respirations: |
| | Salenes suncern | | | | | |
| inal Accecsment | Are you on a regular o | D NC D Wash |) Dressings □ | Allergi Spoard: Rate: Rate: Tube Oxyg | S 73 Of | Initial Contact Date: None Cervic IV Fluids: Airway: None |
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| Medications | it keri | SI LIGHT. | X2r/10 | /8. (*****) | IVE | luids | | i de la did | | igenci (K.). | ty lexity | 38 Jak |
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| | | Pai | n As | sessment | /Reas | sessment | 1948 I.a 1638 (2.a | | | | | |
| Pain Intensity: | | Pain I | ntensi | ity: | ************************************** | | | Intensit | | | | |
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| WIREGRASS MEDIC | CA] AVE | L C | CENT | ÈR | | | O-OF | | UCT | DINJURY INSTRUCTIONS The service of the head may have injuries that cannot alway minimation soon after accident. For the next 24 hours instructions be followed: The service of seleging pills, tranquilizers or alcohol, ordk or play. The ror local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The local hospital immediately if the patient: The hard to awaken. The hard to awaken. The local hospital immediately if the patient: The hard to awaken. Th | | | |
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| 1200 W. MAPLE 1200 W. MAPLE 100 - 01 / 05 (354) 684-36 05 / 23 / 04 | 6340 | Ε. | R. | | 1. MEDI | CAL RECORD NO. | · | 2. BILLING | NO. | | 3. AJI | NO. | |
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| 05/23/04 | 11 71 14 | ٤ | | | 4. CLAS | S 5. DAT | E | 6. TIM | | | C 8. TYPE | 9. SA | ם |
| 10. PATIENTS LEGAL NAME (L.F.MI)? OO # | 1. SEX | 12. RACE | 13. BIRTHDATE | | 14. AGE | 15. HEIGHT | | 16. WEIGHT | 17. SS | 18. MS | 19. | | |
| 20. RP 21. NOTIFY W EMERGENCY | | 22. HON | IÉ TELE | 23. WORK TE | LE . | 24. HOW PAT | IENT ARRI | VED | <u> </u> | <u> </u> | | | |
| | | | | | | | | | | | | | |
| 25. C COMPLAINT 26. | | | 27. PROC CD | 28. PROCEDU | RE | OUTPAT | IENT | SURGERY | INFOR | | N 30. Tii | AE. | 31. ANES |
| 12. PHYSICIAN CALLED | 33. / | ATTENDING I | PHYSICIAN | <u> </u> | | | | 34. FAMILY PHYSIC | IAN | <u> </u> | | | |
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| | | | | | | | | | | | | | |
| SPRAIN, FRACTURE, & SEVERE BRUISES | | В | ACK AND NEC | K INJUR | Y INSTRI | UCTIONS | | | HEA | D INJUR | Y INSTRU | JCTIONS | |
| ☐ Elevate the injured part above level of heart to lessen swelling. If pillo | 11 - | | T OR COLD ON TI | | | ichever seems | to help | Persons who i | eceive blo | ws to the h | ead may ha n after acci | ve injuries th dent. For th | at cannot alwa e next 24 hours |
| flatten, use chair cushions with pillows or blanket for comfort. lee packs also help prevent swelling, especially during the first 48 hou | rs. 🔲 🗆 | Rest as n | nuch as possible u | ntil you are | improved. | | | is important ti | iat these i | instructions | be followed | : | |
| □ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use h □ If you have an elastic bandage, rewrap it if too tight or loose. Remove | | | sitions and movem otionally - if you a | | - | | | where he | s and is n | ot confused | | - | |
| bedtime and replace in A.M. | | Gentle bu | t firm massage wi | | | | | | e taking o | f sleeping p | ills, tranquili | | ol. |
| If you have a cast, keep it perfectly dry at all times. Wiggle toes or fingers to help prevent swelling in the cast—this should | | • | clear the soreness. cial collar when or | ıt of bed. | | | | Call your f | amily docu | tor or local i | hospital imm | ediately if th | e patient: |
| done often if it does not cause pain. If the part swells anyway or gets cold, blue or numb or pain increases | | | | | | | | | | | | | |
| markedly, have it checked promptly | | | | | | | | ☐ Complains | of double | vision | | | |
| Use crutches. | # | | | | | | | ☐ Shows abr | ormal beh | avior such a | as staggerin | g or walking | into things. |
| X-RAY INSTRUCTIONS | \ | | ND CARE (Cut | | ons, Buri | ns, Stitche | s) | | V | OMITING | & DIAR | RHEA | |
| Your X-rays have been read by the attending physician in the Emergent Dept. For your added protection, your X-rays will be reread the next morning | 7 11 | • | dressings clean an e wound to help re | | ss and help : | speed wound h | ealing. | Do not fee | | | | diarrhea offe | er 2 tablesnoons |
| bept. For your added protection, your variants and that have not been called to your aftention, you and your doctor will be called immediately. (Please t | ا تا ا | Despite th | ne greatest care, a red, swollen, shows | ny wound c | an be infects | ed. If your wo | und | (1 ounce) o | f any of t | he following | : clear liqui | ds, Coke, Gi | ngerale, 7-up, |
| to your Atlemon, you and you do to the control of the control of the certain that the Emergency Dept. has a phone number where you can be reached. Sometimes fractures or abnormalities may not show up on X-ray | e c | of less so | re as days go by, y | you must rep | ort to your | doctor right a | way. | teaspoon o | f sugar to | each ounce | of liquid. | - | |
| reached). Sometunes tractures or aunormanties may not show up on Atal for several days. If your symptoms continue or get worse, call your docto More X-rays may need to be taken. If you are referred to another physicial | r. fi 🕳 - | - | should be changed t rendered | in | days. | | | ☐ The 2 table | spoons of | liquid may l | e offered e | ery hour. If | after 4 hours n |
| come by the hospital and pick up your X-ray and take them with you to th | e 11 🗀 1 | | oxiod given of tetanus immuni | e alabulia w | as given. To | complete voi | <u></u> . | 11 - | | | | | |
| doctor's office. Please call ahead to X-ray Dept. | i | nmunizat | ion, you must rece art. Call your phys | ive two add | itional doses | of toxoid 4-6 | | treatment f | or 24 hou | rs. | | | |
| | D V | Varm soa | ks to area 4 times | daily. 20-4 | | ach time. | | Contact yo | ur boctor : | 2 Office 101 | iui tiici iiisti | DC110113 A1161 | 24 1100/3. |
| | | ontinuou | s warm compresse | | 400 | | | | | | DOEDWA | TION. | |
| GENERAL INSTRUCTIONS | | | | ER OVER | | | | | | | | | t: : |
| □ Stay in bed/may go to bathroom. □ Use vaporizor. | | | th lukewarm wate ture increases or p | | | e your family | doctor. | Instructions for that animal is a | | | | iay have bitt | en a human if |
| ☐ Drink large amounts of liquids. | | • | | | | | | 11 — | | | | | narian notify |
| □ Take aspirin every 4 hours □ Avoid any use of injured part. | | | | | | | | | | | | | manan, nom, |
| Allow only limited use of the part. | | | E, | YE INJUR | Υ | | | | | | | | |
| You need not necessarily limit activity. □ Fill Prescriptions given to you from Emergency Dept. and take as | | | jury is potentially | | ana ar auddo | a imanirment | of | | | | | | |
| directed. No driving or any activity requiring mental alertness after receiving | yi vi | sion shou | singly severe disco ald be reported ima | nediately to | your physici | ian or eye spe | cialist | | | | | | |
| medication. | - 11 | elow. o not driv | e with eye patch. | | _ | , | | | , | | | | |
| ADDITIONAL INSTRUCTIONS 100(1) | Se Se | D(| belt | વેવ | 40 | 21100 | 0 - | upl | <i>0</i>) ધ | | Pel | <u> </u> | |
| I hereby acknowledge receipt of all the in may be released before all my medical pro my conditions, worsen or new symptom | oblems | are k | nown or tre | ted. I v | vill arran | ige for fol | low-u | ceived EME ip care as in | RGEN(dicated | CY treat d above | ment or . Tunde | nly and ti rstand th | nat I nat if |
| ATIENT/PARENT'S SPENATURE) | | | GNATURE | el | 15 | Qn | | PHYSICIAN' | S SIGN | ATURE | | | |
| CHOOL AND WORK EXCUSE PAT | IENT N | AME | T. () | | | | | | | D | ATE | | |
| ☐ No work for days | | | | | | ool for | | days | | | | | |
| Light work for days May return to work on | | | | | | /sical Ed eturn to s | | on for | d | ays | | | |
| LI IVIAY I CLUIII LU WUIK UII | | | | | , | | | · | | | | | |

PHYSICIAN'S SIGNATURE

ADVANCE DIRECTIVE

ACKNOWLEDGEMENT

| NAME: Nun Jourel SOC. | SEC. NO: 422 34759 | |
|--|--|--|
| IDENTIFICATION NO: 48817 DAT | E OF BIRTH: $1-y-77$ | |
| PLEASE READ THE FOLLOWING | FOUR STATEMENTS. | |
| I have been given written materials ab or refuse medical treatments | out my right to accept | |
| 2. I have been informed of my rights to Directives. | formulate Advance | |
| I understand that I am not required to Directive in order to receive medical tr care facility. | have been given written materials about my right to accept refuse medical treatments have been informed of my rights to formulate Advance rectives. understand that I am not required to have an Advance rective in order to receive medical treatment at this health e facility. understand that the terms of any Advance Directive that I we executed will be followed by the health care facility and caregivers to the extent permitted by law. CHECK ONE OF THE FOLLOWING STATEMENTS: I HAVE executed an Advance Directive. Date: | |
| PLEASE READ THE FOLLOWING FOUR STATEMENTS. 1. I have been given written materials about my right to accept or refuse medical treatments 2. I have been informed of my rights to formulate Advance Directives. 3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. 4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law. PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS: I HAVE NOT executed an Advance Directive. Signed Date: Date: | | |
| PLEASE CHECK ONE OF THE FOLLO | OWING STATEMENTS: | |
| ☐ I HAVE executed an Advance | Directive. | |
| I HAVE NOT executed an Ad | vance Directive. | |
| | | |
| Witness: | Date: | |

Wiregrass Medical Center

| | • | van de state de la companya de la c | | | egrass medical Center Emergency Physician's Charg | e She | eet | Date: |
|----------|-------------|---|-------------------|-------------|--|-------|-------------|---------------------------------|
| 767 | | • | | | Debridement : | | | imple-Single Layer Cont'd |
| | • | , | R | | 00 Infected Skin | | | Ears, Eyelids, Nose, Lips, |
| ļ | IUNN J | UWEL | E R | + | 40 Partial Skin Thickness | 7 | and | or Mucous Membranes |
| 4 | 188813 | MITCHUM O D MD | | | 41 Skin, Full Thickness | | 19512011 | 2.5 cm or less |
| [| 10 B - 0 l | /08/77 27 MALE | | | 42 Skin and Sub Q Tissue | | 19512013 | 3 2.6 - 5.0 cm |
| (| 05/23/ | 0 4 | | 1951104 | 43 Skin, Sub Q, Muscle | | 195 | 5.1-7.5 cm |
| | - 2 / 2 2 2 | ki. | <u> </u> | 1951104 | 14 Skin, Sub Q, Muscle, Bone | | 19512015 | 7.6 - 12.5 cm |
| | P/PAA | Level of Service | | | Hematoma and Abcess | | 19512016 | 12.6 - 20.0 cm |
| | 195992 | B1 Level I | | | 60 I&D Simple Abcess, Furuncle | | 19512017 | 20.1 - 30.0 cm |
| \vdash | + | B2 Level I | | | 61 I&D Simple Abcess, Complicated/ | 1 | 19512018 | Over 30.0 cm |
| - | | B3 Level III | | | Multiple | | 19512020 | Superficial WD Dehis |
| - | | 34 Level IV | \top | 1951014 | 10 I&D Hematoma Simple | | 19512021 | Superficial WD Dehis-Pack |
| - | | B5 Level V | 1 | 1951016 | 00 I&D Puncture Aspiration, Abcess | | Repai | r/Intermediate-Layered |
| | | 38 Direct Life Support In Transit | 1 | 1954632 | 0 Hemorrhoid, Thrombosed | | Scalp, Axil | ae, Trunk, and/or Extremities |
| - | | 25 Visit with Surgery | | | Burns () | | 19512031 | 2.5 cm or less |
| - | | O1 Critical Care per Hour | | | 0 First Degree Burn, Initial | | 19512032 | 2.6 - 7.5 cm |
| \vdash | | 22 Critical Care per 1/2 hour | 1 | | 0 Small Burn, Debride,Dress | | 19512034 | 7.6 - 12.5 cm |
| - | | 05 NG Lavage/Aspiration | + | | 5 Medium Burn, Debride/Dress | | 19512035 | 12.6 - 20.0 cm |
| | | 75 Ipecac Admin/Observe Gastric | + | | 0 Large Burn, Debride/Dress | | 19512036 | 20.1 - 30.0 cm |
| <u> </u> | 1000011 | emptying | 7.5 | | OB/GYN Procedures | | 19512037 | Over 30.0 cm |
| | | Airway/Pulmonary | | 1955640 | 5 I&D, Abcess, Vulva | N | leck, Hand, | Feet, and/or External Genitalia |
| | 7 | 0 Endotracheal Intubation | | | 0 I&D, Bartholin Abcess | | | 2.5 cm or less |
| - | | 1 FB Removal | +- | | 0 Emergency Vaginal Delivery | | 19512042 | 2.6 - 7.5 cm |
| - | | 0 Tube Thoracostomy | ** | | Arthrocenlesis | | 19512044 | 7.6- 12.5 cm |
| | | Vascular Procedures | | | 0 Arthrocentesis, Small Joint | | 19512045 | 12.6 - 20.0 cm |
| | | Non-Routine Venipuncture | | | 5 Arthrocentesis, Intermediate Joint | | 19512046 | 20.0 - 30.0 cm |
| _ | | 0 IV Therapy Requiring MD | | | Arthrocentesis, Major Joint | | | Over 30.0 cm |
| - | 1939070 | per hour | | | liscellaneous Fractures | | Face, E | ars, Eyelids, Nose, Lips, |
| | 1050207 | 7 Thrombolysis IV infusion | | | Closed Rib Fracture | 1 | | r Mucous Membranes |
| | | Cardiac Procedures | | | Clavicle | | 19512051 | 2.5 cm or less |
| | 1959295 | | | | | | 19512052 | 2.6 - 5.0 cm |
| | | 3 Transcutaneous Pacing | † | 19526750 | Closed Distal Phalangeal | | 19512053 | 5.1 - 7.5 cm |
| | | Cardioversion, Elective | T | 19528490 | Closed Fracture, Great Toe | | 19512054 | 7.6 - 12.5 cm |
| | | Opthamology | | 19528510 | Closed Phalanx other than Gr. Toe | | 19512055 | 12.6 - 20.0 cm |
| | 1956520 | | | Miscell | aneous Closed Dislocations | | 19512056 | 20.1 - 30.0 cm |
| | | FB Conjunctival/Embedded | | 19521480 | TMJ Uncomplicated | | 19512057 | Over 30.0 cm |
| | | FB, Eyelid | | 19523650 | Shoulder w/ Manipulation | | Repair/Co | mplex-Reconstructive or |
| | | ar Nose, and Throat | | 19524640 | Nursemaid's Elbow | | Compli | cated Wound Closure |
| | | FB Pharynx | | 19526700 | Finger, MP Joint | | | Trunk |
| | | FB External Ear Canal | | 19526770 | Finger, IP Joint | | 19513100 | 1.1 - 2.5 cm |
| | 19569210 | Impacted Cerumen | | 19528660 | Toe IP Joint | | 19513101 | 2.6 - 7.5 cm |
| | | FB Intranasal | | Mis | cellaneous Procedures | | | o, Arms, and/or Legs |
| | 19530901 | Anterior Epitaxis, Simple | | 19553670 | Urine Catheterization, Simple | | 19513120 | 1.1 - 2.5 cm |
| | | Anterior Epitaxis, Complex | | 19553675 | Urine Catheterization, Complex | | 19513121 | 2.6 - 7.5 cm |
| | | Posterior Epitaxis, Initial | | 19562270 | Spinal Puncture | | Forehead, C | Cheeks, Chin, Mouth, Neck, |
| | | ue/Foreign Body Removal | | 19564450 | Digital Block | | Axillae, Ge | nitalia, Hands, and or Feet |
| | | Sub Q, Simple | | 19582270 | Stool for Occult Blood | | 19513132 | 1.1 - 7.5 cm |
| | | Sub Q, Complicated | | 19593042 | Rhythm Strip Interpretation | | Eyelids, | Nose, Ears, and/or Lips |
| | | Muscle, Simple | | Repa | air/Simple-Single Layer | | 19513151 1 | .1 - 2.5 cm |
| | | | ***************** | | ate, External Genitalia, Trunk, | | 19513152 2 | 2.6 - 7.5 cm |
| | | Nails : | | | or extremities | | | |
| | | Avulsion/Nail, Simple | 7 | | 2.5 cm or less | | | |
| \neg | | Subungal Hematoma | | 19512002 | 2.6 - 7.5 cm | | | |
| \neg | | | | | 7.6 - 12.5 cm | | | |
| | | | | 19512005 | 12.6 - 20.0 cm | | | |
| \neg | | | | 19512006 | 20.1 - 30.0 cm | | | |
| | | | | | | 1 | | |

Wiregrass Medical Center ER Level of Service Charge Sheet

| | www. lour! | г в | | Integumentary | | |
|-----|---|--------------|-------------|--|--------------|-----------------|
| | NUNN JOWEL | E.R. | | Repair of Nail Bed | 196117 | 60 |
| | 488813 MITCHUM O D MD DOB-01/08/77 27 MALE | • | | Subungal Hematoma | 196117 | 40 |
| | 05/23/04 | • | | Dressing Application | | |
| | 03/23/04 | | ariti | FB removal | 1961012 | 20 |
| | ER/ROOM | | Se 10 | I&D Abcess | 1962000 | 50 |
| | | | | Laceration Repair (simple,intermed) | 1960000 | 50 |
| | | | | Laceration Complex | 1961000 | 50 |
| | Jugular, Cutdown, Central Line | | | Debridement | 1961104 | 10 |
| | Blood Administration | 196364 | 30 | Treatment of Burns | 1961602 | 20 |
| | Cardioversion, Mechanical | 196929 | | Orthopedics | | |
| | Code Blue | 196929 | | Behr Block/Regional Block | | |
| | External Pacemaking | 196929 | | Casting/Splinting | 1962950 | 00 |
| | Intubation | 196315 | | Removal or Revision of Cast | 1962970 | |
| | Immunization (Td, Hepatitis B) | 100010 | - | Tx of fx/dislocation with manipulation | | \top |
| | Immunization (Rabies) | 1969067 | 75 | Compartmental Syndrome | 1962095 | 0 |
| | Medication Administration IV | 1969078 | | Neurological | 100200 | |
| | | 1969078 | | Lumbar Puncture | 1966229 | al l |
| | Medication Administration IM or SQ | 1964908 | | Euribai Functure | 1000220 | +- |
| | Paracentesis | 1964906 | 20 | | | +- |
| | Peritoneal Lavage/Tap | 4000000 | | | | +- |
| | Thoracentesis | 1963200 | | | | - |
| | Pericardiocentesis | 1963301 | | | | |
| | Chest Tube Insertion | 1963200 | 2 | | | - |
| | IV Hydration | ļ | | | | - |
| | CPR | | | | | |
| | ENT BY | | | | | |
| | Eye Irrigation | ļ | | | <u> </u> | - |
| | Eye Exam/Corneal Abrasion | ļ | | | <u> </u> | - |
| | Foreign Body Removal Ear | | | | | - |
| | Foreign Body Removal Nose | | | | · | |
| | Irrigation Ear | | | | | ↓ |
| | Nose Bleed/Nasal Packing | | | | | <u> </u> |
| | Rust Ring (Foreign Body Removal) | | | Treatment Level | | |
| | Respiratory | | | Emergency WD | 19699281 | |
| | Tracheotomy | 19631603 | | Emergency I | 19699282 | |
| - | Cricothyrotomy | 19631605 | | Emergency I with procedure | | |
| - 1 | Trach Change | 19631603 | | Emergency II | 19699283 | V |
| | Gastrointestinal | | | Emergency II with procedure | i | |
| f | Gastric Lavage or NGT insertion | 19691105 | | Emergency III | 19699284 | |
| : , | Gastrostomy Tube Placement | 19643760 | | Emergency III with procedure | | |
| | Genitourinary Genitourinary | de de la | | Emergency IV | 19699285 | |
| 220 | | 19659409 | | Emergency IV with procedure | | |
| | Supra Pubic Cath, or Turkey Tray | | | Critical Care | 19699291 | |
| 1 | | 19651700 | | Critical Care with procedure | | |
| | Pelvic Exam | | | Observation I | | |
| ŀ | | | | Observation II | | |
| + | | | | Observation III | | |
| - | | | | | | \neg |
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WIREGRASS MEDICAL CENTER

1200 W MAPLE AVE

GENEVA

AL 36340

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| GUARANTOR NAME NUNN JOWEL | | | | R ADDRESS SOUTH BE | ROAD S | T | | SAMSON | | | AL 3 | 6477 | | 898- | / U |
| GUARANTOR EMPLOYER SELF | t | | | GUARANTOR | OCCUPATION | N | GUAR. | EMPLOYER A | DDRESS | | | | | GUAR. EMPL | TELEPHONE N |
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| has been made as t 2. The undersigned a 3. I/we hereby assign 4. I/we hereby author appoint the "Contraccount I may owe DATE CHIEF COMPLAI | or the results rees to pay in any hospital ize the "Admi oller" of Hos said hospital | Accident S | d. by Hospital upon re fits, injury benefit l' to furnish from i ttorney to endorse f | elease of patient. ts due to a liabil its records any in for me any checks SIGNED PATIENT | ity of a Third formation requ made payable t | d party, payab uested by the I to me for bene | le by any before me fits or c | party, for the ntioned insuranc laims collected | above pat e compani under the | ient, to Ho es in conne above assi GNED ARANTOR | ospital unle ection with ignment and | ess I pay the a the above assi to apply any c | ecount in | n full upon re I do hereby lance to any o | elease of patient. |
| TEMP. PULSE RE | SP. B/ | PALLERGIES | | • | MEDI | CATIONS - | HOME | | | | | E.R. PE | YSICI | AN | TET. TOX. |
| PHYSICIAN'S R DIAGNO | EPORT | | Gs, etc.) | | | | | | | | | | | | |
| NSTRUCTIONS T | O PATIE | :NT: | | | | | | | | | | | IMP | ONDITION C | N DISC EXPIRED |
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Wiregrass Medical Center 1200 W. Maple Avenue Geneva, Alabama 36340

CONDITIONS FOR TREATMENT

Nunn Jowel 496952

Relationship to Patient

- 1. MEDICAL AND SURGICAL CONSENT FOR TREATMENT: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.
- 2. RELEASE OF INFORMATION: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.
- 3. RELEASE FROM LIABILITY FOR VALUABLES: I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.
- 4. GUARANTOR AGREEMENT: The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.
- 5. ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

ASSIGNMENT OF MEDICARE BENEFITS: PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

ACKNOWLEDGEMENT OF MEDICARE

Signature

Date

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

| Date | Signature | Relationship to Patient |
|------|-----------|-------------------------|

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

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| Patie | ent Name | | | NUNN, JOWEL | OWEL Discharge Date | | | | | |
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| Adm | ission Date | | | 09/27/2004 | Date of Birth | | 01/08/1977 | | | |
| Med | ical Record | Number | | 422847896 | Sex | | Male | | | |
| Age. | | | | 27 | | | | | | |
| Acco | ount Numbe | er | | 496952 | | | | | | |
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| <u>CPT</u> | Code | CPT Modifi | <u>iers</u> | CPT Description | | CPT Date | CPT Surgeon | | | |
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PAGE PRINT DATE: 09/30/04 903 Wiregrass Hospital 01D0304961 Ed Benak M.D. CLIA Number Medical Director H5LACIMV LABORATORY --- CUMULATIVE REPORT TIME: 13:00 PHY..: MCLEOD JIMMY W MD SEX..... M NAME .: NUNN JOWEL ADMIT: 09/27/04 AGE..... 27 Y ACCT#: 496952 MR#..: 422847896 DOB....: 01/08/1977 - NO PENDING ORDERS ROOM .: E.R. PAT. PHONE: 3348989907 MICROBIOLOGY --VERIFIED-----RESULTED----REC'D----ORDERED----COLLECTED--9/30/04 1022 9/27/04 1116 9/30/04 1022 9/27/04 1013 9/27/04 1013 PAG PAG NLSRLCULTURE MISC. SOURCE ** FINAL ** MICROBIOLOGY REPORT SUMMARY ---- Antimicrobial Susceptibility and Organism Identification Report --Specimen Number : 04365 Specimen Source : MISC. CULTURE Requested: Collected: 09/27/04 10:13 Received : 09/27/04 11:16 Ward of Isolation : WIREGRASS HOSP Requesting Physician : ER PHYSICIAN Miscellaneous Tests and Comments NO GROWTH FINAL REPORT Comments: rt wrist Organisms Identified Comments Tested Identity

903 Page:

LAST

** FINAL **

ID # : 496952

Susceptibilities, if performed, appear on the following page(s).

Report Date : / / :

Source : MISC. CULTURE Collected : 09/27/04 10:13

NUNN 'JOWEL E.R. 496952 MCLEOD JIMMY W MD DOB-01/08/77 27 MALE 09/27/04 Wir

Wiregrass Medical Center

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1-8-87

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| nstructions to Pt: (1) Rx: bx tun Ds TB1D#14 | "Back colere | out |
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| B) Follow up: 500 mb T wk | v | |
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| hysician's Signature: | Family Di | Mobile |

| NUNN JOWEL 496952 MCLEOU DOB-01/08/77 09/27/04 ER/ROOM Initial Contact Time: | Addressograph Addressograph Allergies: | Are you on a regular | Stretcher |
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| Respirations: | | To Pain 2 No Response 1 Best Motor Obeys 6 Response Localizes Pain 5 Flexion-Withdrawal 4 Flexion/Abnormal 3 (Decorticate Rigidity) | ☐ Alert ☐ Responds to Void ☐ Responds to Pain ☐ Unresponsive ☐ Lethargi Orientation: ☐ Appropriate Response ☐ Inappropriate Response Pupils: Brisk ☐ L ☐ R Sluggish ☐ L ☐ R Nonreactive ☐ L ☐ R Size: L: |
| □ Vomiting □ Diarrhea □ Constipation □ LBM: □ Bowel Sounds: □ Present □ Absent Comments: □ Yes □ No Frequency □ Yes □ No Vaginal Bleeding: □ Yes □ No □ Scant □ Moderate □ Large □ Tay □ Para □ Ab □ □ Comments: | Location (circled above) Radiation (arrow above) | Incomprehensible Sounds 2 No Response 1 GCS Total (3-15): Location(s): Size(s): Bleeding Controlled: Yes No Comments: Full Range of Motion Y N Pulse: Y N Sensation Intact: Yes No Ext Deformity: Yes No Full ROM: Yes No | Hand Grasp: L R Strong □ □ Weak □ □ Absent □ □ Slurred Speech? □ Yes □ No Eye Contact □ Y □ N Affect: □ Normal □ Flat □ Cooperative □ Disoriented □ Combative □ Anxious Do you feel safe in your present living environment? □ Yes □ No If no, would you like to talk to someone? □ Yes □ No |
| Severity: O 1 2 3 4 5 6 Exacerabated By: Relieved By: | 7 8 9 10 | Pulse: Cap. Refall: □ Brisk □ Slow Tepap: □ Warm □ Cold S Sensation Intact: □ Yes □ No | Comments: |

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WIREGRASS MEDICAL CENTER 1200 W. MAPLE AVE. GENEVA, AL 36340

ED-OP **HOME INSTRUCTION SHEET**

| (334) 684-3655 | | | | | | | COND NO. | 2.1 | 2. BILLING NO. 3. AN NO. | | | | | | | |
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| ZO RP 21. NOTIFY IN EMERGENCY | | | | | | | ·· | <u></u> | | | \bot | | | | | |
| | Ε | R . | AE TELE | 23. WORK TE | .E | ľ | 24. HOW PATIENT ARR | IVED | | | | | | | | |
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| ER/ROOM | | | | | | | | | | | | • | | | | |
| SPRAIN, FRACTURE, & SEVERE BRUISES BACK AND NECK INJUR | | | | | | | IONS | | HE | AD INJ | URY | INST | RUCTIO | ons | | |
| □ Elevate the injured part above level of heart to lessen swelling. If pillow flatten, use chair cushions with pillows or blanket for comfort. □ Ice packs also help prevent swelling, especially during the first 48 hours □ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat of the first 48 hours, use heat bedtime and replace in A.M. □ If you have an elastic bandage, rewrap it if too tight or loose. Remove a bedtime and replace in A.M. □ If you have a cast, keep it perfectly dry at all times. □ Wiggle toes or fingers to help prevent swelling in the cast—this should be done often if it does not cause pain. □ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly. □ Use crutches. | o burn yourse intil you are in ent that mak ire tense the p | lf. nproved. e the pain problem w | is important that these instructions be followed: Awaken the patient every two hours, even at night where he is and is not confused. Check eyes to see that both pupits are of equal size Prevent the taking of sleeping pills, tranquilizers or Restrict excessive work or play. Call your family doctor or local hospital immediately Develops a severe headache. Vomits more than twice within a short time. Is confused, faints or is hard to awaken. Has a pupil of one eye larger that the other Complains of double vision | | | | | | | For the ne t, to be si e. alcohol. | xt 24 hours i | | | | | |
| X-RAY INSTRUCTIONS | 7 | WOU | ND CARE (Cut | ts, Abrasio | ns, Bur | rns, S | Stitches) | | | VOMITI | NG 8 | d DIA | RRHEA | | | |
| Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept. | D Be of of of the of th | levate the espite the ecomes refees sorressing si reatment etanus To fo units comunization eeks aparam soak | dressings clean an a wound to help re e greatest care, a add, swollen, shows e as days go by, y hould be changed rendered | elieve soreness ny wound can s pus or red st you must repo in el globulin was ive two addit ician for the daily. 20-40 | be infect reaks, or rt to your days. given. T onal dose next dose. | ted. If feels m docto o com | your wound nore sore instead or right away. | □ Do not feed anything for 4 hours. □ After 4 hours, if there is not vomiting and/or diarrhea, offer 2 tabk (1 ounce) of any of the following: clear liquids, Coke, Gingerale, weak tea, Gatorade or Jello, water. If patient is hungrey you mit teaspoon of sugar to each ounce of liquid. □ UNDER NO CIRCUMSTANCES USE MILK OR MILK PRODUCTS. □ The 2 tablespoons of liquid may be offered every hour. If after 4 vomiting has occured, the amount may be slowly increased. □ Using no more than ½ glass (4 ounces) of liquid at a time continu treatment for 24 hours. □ Contact your doctor's office for further instructions after 24 hours. | | | | | | | ale, 7-up, u may add 1 s. r 4 hours no tinue this | |
| GENERAL INSTRUCTIONS | | - | FEVI | ER OVER | 102 | | | | , | ANIMAL | OBS | ERVA | ATION | | | |
| Stay in bed/may go to bathroom. | o s₁ | onge wit | h lukewarm wate | r in the tub. | | | | Instruction | s for observ | ation of an | v anim | al that | may have | e bitten a | human if | |
| Use vaporizor. | □ If | temperat | ure increases or p | ersists for 24 | hours, se | e you | family doctor. | that anima | l is available | for observ | ation. | - | • | | | |
| □ Drink large amounts of liquids. □ Take aspirin every 4 hours | L | | | | | | | i i | nimal taken wner should | | | | | Vetennari | an notify | |
| Avoid any use of injured part. | | | | | | | | | anty Health (| | | | a to the | V C LC I II I II I | an, notny | |
| ☐ Allow only limited use of the part. | l | | EY | E INJURY | , | | | | | | | | | | | |
| ☐ You-need not necessarily limit activity. ☐ Fill Prescriptions given to you from Emergency Dept. and take as | □ An | y eye inju | ıry is potentially h | azardous. | | | | | | | | | | | | |
| directed. | | | ingly severe disco d be reported imm | | | | | | | | | | | | | |
| No driving or any activity requiring mental alertness after receiving medication. | belo | | a ne rehorten mun | ecuatery to yo | iui piiysic | ian oi | eye specialist | | | | | | | | l | |
| HEULALIVI. | □ Do | not drive | with eye patch. | | | | | | | | | | | | | |
| ADDITIONAL INSTRUCTIONS Fullin | | u (| لت، د | \sim | -13 | بر، | <u>~</u> | 2 mi | ير) . | شد(۱ | | | | | | |
| I hereby acknowledge receipt of all the ins | | one in | diantad abov | un Lund | oretan | d th | at I have re | noived El | MEDGEN | ICV tro | atm. | ont o | | d that | | |
| may be released before all my medical prob | olems | are kn | own or trea | ted. I wi | ll arran | nge f | or follow-u | p care as | indicate | ed abov | ∕e. I | unde | erstand | d that i | f | |
| my conditions worsen or new symptoms | appea | r, Ish | ould contac | | | | iately. | | | | | | | | | |
| ATIENT/PARENT'S SIGNATURE | NURSI | E'S SIC | SNATURE | | | | | PHYSICIA | N'S SIGN | IATURE | | | | | | |
| CHOOL AND WORK EXCUSE PATIE | NT NA | ME | 1 | | | | | | | | DAT | Έ | | | | |
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| VIREGRASS MEDICAL CENT | TEF | ? | PHYSIC | CIAN'S SI | GNATU | RE | | | | | | | | | | |

ADVANCE DIRECTIVE

ACKNOWLEDGEMENT

| NAME: Nun Jowel s | OC. SEC. NO: 422847896 |
|---|----------------------------|
| IDENTIFICATION NO: 496952 D | |
| PLEASE READ THE FOLLOWIN | G FOUR STATEMENTS. |
| 1. I have been given written materials or refuse medical treatments | about my right to accept |
| 2. I have been informed of my rights Directives. | to formulate Advance |
| I understand that I am not required Directive in order to receive medical care facility. | |
| 4. I understand that the terms of any A have executed will be followed by the my caregivers to the extent permitted | e health care facility and |
| PLEASE CHECK ONE OF THE FOLI | LOWING STATEMENTS: |
| ☐ I HAVE executed an Advan | ce Directive. |
| I HAVE NOT executed an A | Advance Directive. |
| Signed | Date: |
| Witness: | Date: |
| Witness: <u>Canestine</u> Shwer | Date: <u> </u> |

Wiregrass Medical Center

Emergency Physician's Charge Sheet

| | | | | V | | egrass Medical Center | - 01 | | D (| |
|--------------------|--|----------------------------------|--|-------------|----------------------|------------------------------------|------------------|--|---------------------------------|-----------------|
| | | • | ı | | Contract Contract | mergency Physician's Charg | | | | |
| | NÙ | NN JOWEL | | | | Debridement 2 | | | | d · · · |
| | 49 | 6952 MCLEOD JIMM | Y W | | | 0 Infected Skin | 4 | | , Ears, Eyelids, Nose, Lips, | , |
| | D0 | B-01/08/77 27 | M A | | | 0 Partial Skin Thickness | | | d/or Mucous Membranes | |
| | 09 | /27/04 | | | | 1 Skin, Full Thickness | 4_ | | 11 2.5 cm or less | |
| | | | - } | | | 2 Skin and Sub Q Tissue | | | 13 2.6 - 5.0 cm | |
| | ER | /R 00 M | - | | | 3 Skin, Sub Q, Muscle | ╀- | | 14 5.1-7.5 cm | |
| | | | | 1951 | With Contract of the | Skin, Sub Q, Muscle, Bone | _ | | 15 7.6 - 12.5 cm | |
| | | Level of Service | | <u> </u> | 1. 100000 | lematoma and Abcess | 4 | | 16 12.6 - 20.0 cm | |
| <u></u> | | 31 LeveLL | | | | I&D Simple Abcess, Furuncle | — | | 17 20.1 - 30.0 cm | <u> </u> |
| <u></u> | | 2 Level II | | 1951 | 0061 | I&D Simple Abcess, Complicated/ | ļ | | 8 Over 30.0 cm | |
| <u> </u> | | 3 Level III | | | | Multiple | ↓ | | 20 Superficial WD Dehis | |
| <u></u> | | 4 Level IV | | | | I&D Hematoma Simple | | | 1 Superficial WD Dehis-Pack | COLUMN TOWN |
| <u></u> | | 5 Level V | -+ | | | I&D Puncture Aspiration, Abcess | | | iir/Intermediate-Layered | 5000000-1100000 |
| <u> </u> | | 8 Direct Life Support In Transit | | | | Hemorrhoid, Thrombosed | ļ | | illae, Trunk, and/or Extremitie | s |
| <u></u> | | 5 Visit with Surgery | | | | Burns | ļ | | 1 2.5 cm or less | |
| | | 1 Critical Care per Hour | | | | First Degree Burn, Initial | | | 2 2.6 - 7.5 cm | |
| | | 2 Critical Care per 1/2 hour | | | | Small Burn, Debride, Dress | <u> </u> | | 4 7.6 - 12.5 cm | |
| L | | NG Lavage/Aspiration | | | | Medium Burn, Debride/Dress | ļ | | 5 12.6 - 20.0 cm | |
| | 1959917 | 5 Ipecac Admin/Observe Gastric | L | 19516 | CONT. Photo | Large Burn, Debride/Dress | | 1951203 | 6 20.1 - 30.0 cm | |
| | | emptying | | | (| DB/GYN Procedures | | 1951203 | 7 Over 30.0 cm | · |
| | | Airway/Pulmonary | | 19556 | 405 | I&D, Abcess, Vulva | N | eck, Hand | Feet, and/or External Genital | lia |
| | 19531500 | Endotracheal Intubation | | 19556 | 420 | I&D, Bartholin Abcess | | 1951204 | 2.5 cm or less | |
| | 19531511 | FB. Removal | | 19559 | 410 | Emergency Vaginal Delivery | | 1951204 | 2.6 - 7.5 cm | |
| | 19532020 | Tube Thoracostomy | | | | Arthrocentesis | | 1951204 | 7.6- 12.5 cm | |
| | V | ascular Procedures | | 195206 | 600 | Arthrocentesis, Small Joint | | 1951204 | 12.6 - 20.0 cm | |
| | 19536410 | Non-Routine Venipuncture | | 195206 | 305 | Arthrocentesis, Intermediate Joint | | 19512046 | 20.0 - 30.0 cm | |
| | 19590780 | IV Therapy Requiring MD | | 195206 | 10 | Arthrocentesis, Major Joint | | 19512047 | Over 30.0 cm | |
| | | per hour | | | Mis | cellaneous Fractures | | Face, I | ars, Eyelids, Nose, Lips, | |
| | 19592977 | Thrombolysis IV infusion | T | 195218 | 00 | Closed Rib Fracture | | | or Mucous Membranes | |
| | C | ardiac Procedures | | 195235 | 00 0 | Clavicle | | 19512051 | 2.5 cm or less | |
| T | 19592950 | CPR | | 195237 | 20 0 | Closed Phalangeal Shaft | | 19512052 | 2.6 - 5.0 cm | |
| | | Transcutaneous Pacing | 1 | | | Closed Distal Phalangeal | | 19512053 | 5.1 - 7.5 cm | |
| - -† | | Cardioversion, Elective | | | | Closed Fracture, Great Toe | | | 7.6 - 12.5 cm | |
| \neg | | EKG Interpretation | \top | | -+ | Closed Phalanx other than Gr. Toe | | | 12.6 - 20.0 cm | |
| | | Ophthalmology | 1 | | | | | | 20.1 - 30.0 cm | - |
| T | 19565205 | | | Misce | llan | eous Closed Dislocations | | | Over 30.0 cm | \neg |
| \neg | | FB Conjunctival/Embedded | 10000000 | 1 | | MJ Uncomplicated | | | | |
| - | 19567938 | | + | | -+- | houlder w/ Manipulation | | Renair/Co | mplex-Reconstructive or | |
| | | Nose, and Throat | | | | lursemaid's Elbow | | | cated Wound Closure | \equiv |
| Ť | T | FB Pharynx | | | -+- | inger, MP Joint | | | Trunk | |
| | | FB External Ear Canal | + | | | inger, IP Joint | | 19513100 | 1.1 - 2.5 cm | \dashv |
| | | mpacted Cerumen | + | | | oe IP Joint | | | 2.6 - 7.5 cm | \dashv |
| | | FB Intranasal | | | | llaneous Procedures | 1 | | o, Arms, and/or Legs | \dashv |
| | | Anterior Epitaxis, Simple | | | | rine Catheterization, Simple | | | 1.1 - 2.5 cm | \dashv |
| | | Anterior Epitaxis, Complex | + | | +- | rine Catheterization, Complex | | | 2.6 - 7.5 cm | \dashv |
| | ——— - | Posterior Epitaxis, Initial | +- | | _ | pinal Puncture | | | Cheeks, Chin, Mouth, Neck, | \dashv |
| Anna Canada | and the second s | e/Foreign Body Removal | 1 | | _ | gital Block | | | nitalia, Hands, and or Feet | \dashv |
| No. of Concessions | | Sub Q, Simple | | + | | ool for Occult Blood | | | 1.1 - 7.5 cm | \dashv |
| | | Sub Q, Complicated | | + | + | nythm Strip Interpretation | | | Nose, Ears, and/or Lips | \dashv |
| | | fuscle, Simple | | <u> </u> | | Simple-Single Layer | T 4 | | .1 - 2.5 cm | \dashv |
| | | fuscle, Simple | | | | External Genitalia, Trunk, | _ | | .1 - 2.5 cm | \dashv |
| | | Nails | Judi | | | · - | - ' | 00 10 102 2 | u - 1.J GII | \dashv |
| 1 | | | \vdash | | _ | extremities | + | | | \dashv |
| | | vulsion/Nail, Simple | | | + | cm or less | \dashv | | · | \dashv |
| +1 | 9512/40 S | ubungal Hematoma | <u> </u> | 19512002 | + | | - | | | \dashv |
| + | | | | | | - 12.5 cm | + | | | \dashv |
| + | | | | | | 6 - 20.0 cm | + | | | \dashv |
| + | | | | | | 1 - 30.0 cm | - | | | _ |
| | | | | 19512007 | Ονε | er 30.0 cm | | | | |

The second secon

| | , , | | | | Miss was Madical Conto |
|----|--------------|------------------------------------|--------------|----------------------|---|
| | ииии Јо | WEL E.R. | | | Wiregrass Medical Center ER Level of Service Charge Shee |
| 4 | 406952 | MCLEOD JIMMY W MD | | _ | Integumentary |
| | DOB-01/ | 08/77 27 MALE | | 4004470 | Repair of Nail Bed |
| | 09/27/0 | | ļ | | O Subungal Hematoma |
| į. | 0 // 2 / / 0 | · | | 19611740 | Dressing Application |
| | ER/ROOM | | <u> </u> | 4004040 | FB removal |
| | 2, | | - | |) I&D Abcess |
| 1 | | | <u> </u> | 19620000 | Laceration Repair (simple,intermed) |
| | | | | 19600000 | Laceration Complex |
| | 10.0 | Circulatory | _ | | Debridement |
| | | Jugular,Cutdown, Central Line | - | | Treatment of Burns |
| | | Blood Administration | - | 19616020 | Orthopedics |
| | | Cardioversion, Mechanical | | | Behr Block/Regional Block |
| | 19692950 | Code Blue | | 40C20E00 | Casting/Splinting |
| | 19692953 | External Pacemaking | ļ | 19029300 | Removal or Revision of Cast |
| | 19631500 | Intubation | ├ | 19629703 | Tx of fx/dislocation with manipulation |
| | 19690471 | Vacine Admin. (other than Rabies) | ↓ | 40000050 | |
| | 19690675 | Vacine Administration (Rabies) | | 19620950 | Compartmental Syndrome Neurological |
| | 19690784 | Medication Administration IV | | 4000000 | Neurologicar |
| | | Medication Administration IM or SQ | | 19662290 | Lumbar Puncture |
| | 19690780 | IV infusion-up to 1 hour | <u> </u> | | |
| | | IV infusion-each additional hour | <u> </u> | | |
| | 19649080 | Paracentesis | | | |
| | | Peritoneal Lavage/Tap | <u> </u> | | |
| | 19632000 | Thoracentesis | <u> </u> | | |
| | | Pericardiocentesis | | | |
| | 19632002 | Chest Tube Insertion | | | |
| | | IV Hydration | | | Other |
| | | | | 19682962 | Glucose fingerstick |
| | 1.0 | ENT | | | |
| | | Eye Irrigation | | | |
| | | Eye Exam/Corneal Abrasion | | | |
| | | Foreign Body Removal Ear | <u></u> | | |
| | | Foreign Body Removal Nose | | | |
| | | Irrigation Ear | | | |
| | | Nose Bleed/Nasal Packing | | | Treatment Level |
| | | Rust Ring (Foreign Body Removal) | | | |
| | | Respiratory | - /- | | Emergency WD |
| | 19631603 | Tracheotomy | ~ | 19099 282 | Emergency I with procedure |
| | | Cricothyrotomy | | 1000000 | |
| | 19631603 | Trach Change | | 19699283 | Emergency II Emergency II with procedure |
| | | Gastrointestinal | | 40000004 | Emergency III |
| | | Gastric Lavage or NGT insertion | | 19699284 | Emergency III with procedure |
| | | Gastrostomy Tube Placement | | 40000005 | |
| | | Genitourinary | | 19699285 | Emergency IV Emergency IV with procedure |
| | 19659409 | Delivery/Birth | | 10000001 | Critical Care |
| | | Supra Pubic Cath, or Turkey Tray | | 19699291 | Critical Care Critical Care with procedure |
| | | Irrigation of Catheter | | | Observation I |
| | | Pelvic Exam | | | Observation II |
| | | | | | Observation II |
| | | | | | ODSELVATION III |
| | | | | | |
| | | · | | <u> </u> | |

WIREGRASS MEDICAL CENTER 1200 W MAPLE AVE

GENEVA

AL 36340

| PATIENT NUMBER | TYPE | PATIENT NAME | | | ····. | | GE E | IRTHDA | | | | | | | | | NT RECC |
|---|---------|--------------|----------|---------------|--------------------|--------|---|------------------------------------|----------------------------------|---|----------|--|--------|-----------------------------|---|---|----------------------------|
| 513688 | 3 | MOL MUNN | | | | | 28 | | 8/1 | | SEX M | M/S SB | 6/C | 4/0 | | 16:45 | JLS |
| ADDRESS - LINE 1 202 SOUTH BI | ROAD | ST | ADDRE | SS - LINE 2 | 2 | | | | SAN | MSON | | | STATE | | CODE 477 | 334- | NE 898-990 |
| PATIENT SSAN 422847896 | | NUNN LIN | | | | MOT) | | P | | ADDRESS | | | SAMS | ON | AL | 334- | NE 898-990 |
| INSURANCE COMPANY | | Lau, | ~ | | | | CONTR | ACT OF | GROUI | PNUMBER | | | DATE | | PLACE | 1 | 7 |
| | | | | | | | | | | | | | TIME | | EVENT | | |
| GUARANTOR NAME | | | | TOR ADDRESS | _ | | | | CIT | | | | TATE Z | | | l l | ELEPHONE |
| NUNN JOWEL GUARANTOR EMPLOYER | | | 202 | SOUTH | BROAL TOR OCCUP | | | GT | E | AMSON MPLOYER | ADDRESS | | AL 3 | 647 | 7 | | 9907 |
| SELF PREV. SERVICE | PREV | . SERV. DATE | IF MINOR | - PARENT N | NAME | | | C | | TY JA | | | LADMIT | ring/2 | ND PHYS | ICIAN | |
| 496952 | X-RAY | /27/04 | RESP. TE | . PHY. T | · I · · | EKG | - | I.V. | | 12284 | 7896 | | KRA | FT | KURT/ | MITCHUN | |
| CHARGES | | | | LATION FOR TR | | | | | | DRUGS | | PLIES | OTHE | | M.D. | E.R. RM | TOTAL DUE |
| The undersigned has be employees of the hosp has been made as to t. The undersigned agree. If we hereby assign any temporary authorize appoint the "Controlla account I may owe said the controlle account I may one SPIDER BITE. The undersigned agree of the property of the controlla account I may one said the controlla account I may one said the controlla account I may one said the controllation. | | TIME | | SIG | NED IENT | | party, p. sted by me for l | ayable by the befor benefits | any par e mention or claim | ty, for the ned insurance s collected | SI | ent, to Ho es in conne above assi GNED ARANTOR | | ess I p the ab to app | ay the acco ove assignm ly any cred | unt in full upon ent. I do hereby it balance to any | release of patien other |
| TEMP. PULSE RESP. | . В/Р | ALLERGIES | | | | MEDICA | MT ONC | - HON | TD | | | | | - 1= | | | T |
| | | | | , | | MEDICA | MIIONS | - AOR | | | | | | . | .R. PHYS | ICIAN | TET. TO |
| NURSES NOTES: | | | | | | | | | | | | | | | | | |
| PHYSICIAN'S REP | ORT | - | | | | | | | | | | | | | | | |
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| DIAGNOS | SIS | 5: | | | | | *************************************** | | | | | | | | | | |
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| REATMENT: | | | | | | | | | | | | | | | | CONDITION (| |
| REATMENT: | PATIEN | TT: | | | | | | | | | | | | | IM | | ON DISC EXPIRED |
| | PATIEN | T: | | <u> </u> | | | **** | | | | | | FOI | LLOW-U | IM | | |

M.D.

Wiregrass Medical Center 1200 W. Maple Avenue Geneva, Alabama 36340 NUNN JOWEL E.R. 513688 KRAFT KURT D DOB-01/08/77 28 NALE 06/04/05

CONDITIONS FOR TREATMENT

- 1. MEDICAL AND SURGICAL CONSENT FOR TREATMENT: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.
- 2. RELEASE OF INFORMATION: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.
- 3. RELEASE FROM LIABILITY FOR VALUABLES: I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.
- 4. GUARANTOR AGREEMENT: The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.
- 5. ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

Patient

Patient's Agent or Representative

Relationship to Patient

ASSIGNMENT OF MEDICARE BENEFITS: PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUEST

"I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services or authorize such physician or organization to submit a claim to Medicare for payment to me. I understand that I am responsible for Part A deductible for each spell of illness, the Part B deductible for each year, the remaining 20% of reasonable charges and any personal charges incurred."

Date Signature Relationship to Patient

ACKNOWLEDGEMENT OF MEDICARE

I hereby declare I am a participant in the Medicare Program and I am not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid group practice. I understand that if it is found that I am a participant in any of the above mentioned practices, I will be considered a self-pay patient required to pay in full immediately.

| Date | Signature | Relationship to Patient |
|------|-----------|-------------------------|
| | | |

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

Р

| Dationt | Mama | | NUNN, JOWEL | | Discharge Dat | e | 06/04/2005 |
|--------------------|-------------|-----------------------|------------------------|---|-----------------|-----------------|-------------|
| | | | | | _ | | |
| | | | | | | | |
| Medica | ıl Record | Number | 422847896 | | Sex | | Male |
| Age | | | 28 | | | | |
| Accoun | nt Numbe | er | 513688 | | | | |
| | | | | | | | |
| | <u>Code</u> | DX Description | · | | | | |
| 1 6 | 82.3 | Cellulitis/Absces | s of Upper Arm/Forearm | | | | |
| PR C | `odo | PR Description | | | Procedure Date | Surgeon | |
| <u>rn</u> <u>c</u> | ode | Ph Description | | | 1 Toccadio Bato | <u>ouigooii</u> | |
| | | | | | | | |
| CPT C | ode | CPT Modifiers | CPT Description | , | | CPT Date | CPT Surgeon |
| | | | | | | | |
| | | APC PSI | Payment Rate | | | ASC Group | ASC Fee |
| | | | | | | | |
| | | | | | | | |
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| Attendin | ng Physic | ian | 001600 | | | | |
| | | ician | | | | | |
| | • • | sition | | | | | - |
| DRG = | 9 | | | | | | |
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| Status | | | ••• | | | | |
| Memo | | | | | | | |
| DRG | | | | | | | |
| MDC | | Weight | AMLOS | | GMLOS | LO | S |

06/06/2005

Page 1 of 1 Coder: TRACEYM

Case 1:06-cv-00452-MEF-CSC Document 13-6 Filed 08/07/2006 Page 99 of 134 PAGE 1 Wiregrass Medical Center PRINT DATE: 06/09/05 049 01D0304961 1200 W. Maple Ave Ed Benak M.D. CLIA Number Geneva, AL 36340-1642 Medical Director H5LACUMV LABORATORY --- CUMULATIVE REPORT TIME: 13:14 PHY..: KRAFT KURT D SEX..... M NAME .: NUNN JOWEL ADMIT: 06/04/05 AGE..... 28 Y ACCT#: 513688 MR#..: 422847896 - NO PENDING ORDERS DOB.....: 01/08/1977 ROOM.: E.R. PAT. PHONE: 3348989907 MICROBIOLOGY --VERIFIED-----RESULTED----COLLECTED----REC'D----ORDERED--6/07/05 1058 6/07/05 1058 6/04/05 2157 6/04/05 1724 6/04/05 1724 LJL DD LJLTB CGB CULTURE MISC. SOURCE L ARM WOUND SPECIFIC SITE:

> ** FINAL ** MICROBIOLOGY REPORT ----- Antimicrobial Susceptibility and Organism Identification Report --

Requested: 06/04/05

Specimen Number : 50707 Specimen Source : MISC. CULTURE Collected: 06/04/05 17:24 Specimen Source Ward of Isolation : NURSING EMERGENCY ROOM 00:00 Received : / /

Requesting Physician : KURT D. KRAFT

Patient/Specimen Tests and Comments

Specimen Comments

HEAVY GROWTH ISO#1 COAGULASE POSITIVE STAPH

Organisms Identified

06/07/05 * 01 Staphylococcus aureus Comments

This S. aureus does not demonstrate inducible clin

<=2

Levofloxacin

damycin resistance in vitro. ** FINAL ** MICROBIOLOGY REPORT

----- Antimicrobial Susceptibility and Organism Identification Report ------

Staphylococcus aureus

Staphylococcus aureus DRUG MIC Interp <=8/4 Amp/Sulbactam BLAC 2 Ampicillin Amox/K Clav Azithromycin Chloramphenicol Ceftriaxone <=8 <=0.5 Clindamycin <=8 Cefotaxime <=8 Cefazolin

S <=1 Ciprofloxacin Erythromycin Gatifloxacin Gentamicin <=4 <=4 Imipenem

049 Page: 1 CONTINUED PRIMI: 06/09/05 13:14 NUNN JOWEL

Case 1:06-cv-00452-MEF-CSC Document 13-6 Filed 08/07/2006 Page 101 of 134

PRINT DATE: 06/09/05 049

Ed Benák M.D. Medical Director Wiregrass Medical Center 1200 W. Maple Ave

Geneva, AL 36340-1642 LABORATORY --- CUMULATIVE REFORT

PAGE 01D0304961 CLIA Number H5LACUMV

NAME.: NUNN JOWEL

ROOM.: E.R.

ACCT#: 513688

TIME: 13:14

SEX..... M

AGE..... 28 Y

DOB.....: 01/08/1977 PAT. PHONE: 3348989907 PHY..: KRAFT KURT D

ADMIT: 06/04/05 MR#..: 422847896

MICROBIOLOGY

| Linezolid | <=2 | S | |
|---------------------------|------------|----------------------|--|
| Moxifloxacin | <=2 | 5 5 | |
| Oxacillin | <=0.25 | S BLAC | |
| Penicillin | A . A | a | |
| Pip/Tazo Rifampin | <=4 241 | S. | |
| Kilampin mrimoth/Culfa | | | |
| Tetracycline | ζ=4 | 5 5 | |
| Vancomycin | <=2 | r | |
| Validation | | B-Lactamase Positive | |
| | | | |

= Susceptible = Intermediate CC = Cost Code MIC = mcg/ml (mg/L)

- NO PENDING ORDERS

N/R = Not Reported --- = Not Tested

BLac = Beta Lactamase Positive TFG = Thymidine-dependent Strain Blank= Data not available, or drug not advisable or tested

= Resistant

For Blood and CSF Isolates, a Beta-Lactamase test is recommended for Enterococus species.

IB appears in place of S, I (S), +, ++, or +++ with species known to possess inducible B-lactamases; potentially they may become resistant to all B-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined B-lactam drugs.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.

(b) Breakpoints based on parenteral dose. For cefuroxime Axetil (PO) use <8=S, 8-16=I, >16=R.
(c) For streptococci (including enterococci), Micrococcus species, and Listeria species, refer to the Ampicillin interpretation. If Ampicillin results are unavailable, refer to Penicillin. If Pen result is resistant, test Ampicillin using an alternate method.

Interpretations based on NCCLS M7-A3. Pip/Tazo for streptococci and enterococci based on manufacturer's breakpoints.

Report Date : / /

Source : MISC. CULTURE Collected: 06/04/05 17:24 ID # : 513688

** FINAL **

E.R. NUNN JOHEL 513688 KRAFT KURT D MALE DOF-01/08/77 28 06/04/05 Wiregrass Medical Center



| wel Nunn | 1 |
|----------|---|
|----------|---|

| Triage Notes: 38 Up Male 10 18 Um M 18 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 18 Um M 18 Um M 18 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 18 Um M 18 Um M 18 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urgent () Urgent () Urgent () Urgent () Non-En Triage Notes: 38 Up Male 10 Urgent () Urge |
|--|
| Allergies: NKA Allergies: NKA LMP: Sp02: 987, Resp: 20 Meds: MNNC Nurse Signature: MADDING ON H&P and CC: Cellulitis (1) Arm PMH: ASTMAN HOW KCVE HPI: PT I light in (2) Arm Surg: NEVMAN Social/Habits: Of Oh. OF ETOH |
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| General: Scar MDD Family Hx: (') |
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| Lungs: Cardio/Resp: |
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| Abd/Rectal: Clearate (4 biccop = Other: |
| GU/Gyn: Saco A All Lit |
| Ext/Skin: |
| Dx: Cellulito (C) Aur |
| Physician's Orders: CBC() BMP/CMP Medication Ini |
| KG() ABG() PT/PTT() Reception in TB |
| VA(Rout)(Cath) Amylase() |
| XR() Other Studies WOUND (1=15 US() |
| M() O2() Foley() IV: |
| isposition: Home()) Dr. Office() Surgery() Expired() Adm Rm# AMA/LWBS() Date/Time: |
| ransfer to C/O Dr. Via |
| ondition at Discharge/Transfer: Improved() Stable(X) Deteriorated() Unchanged() |
| structions to Pt: (1) Rx: Botton D3 #36 |
| Instructions: Restaurant Andrews |
| Follow up: |
| gning this form denotes that I have reviewed all information on this document and I agree: |
| sysician's Signature: Family Dr. /WTChUM |

| Date 06/04 06/04 Time 16:32 17:19 NiBP Systolic 148 149 NiBP Diastolic 105 98 NiBP Diastolic 105 98 NiBP Mean 119 110 HR Avg — — VPC — — VPC — — ST(II) — — SpO2 97 95 SpO2/PR 110 110 |
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NUNN JOWEL 513688 KRAFT KURT DE DOB-01/08/77 28 MALE 06/04/05

ER/ROOM

| MANAMOLI | □ Xes □ No | Sensation Intact: | eter of sldanu 14 🔼 — | Relieved By: |
|--|---|--|---|--|
| 1 1100 MILLAND | Warm Cold | Temp. | | Exacerabated By: |
| e atmining satemy at | Brisk 🗆 Slow | Cap. Refill | 0I 6 8 L | 9 5 7 5 7 10 |
| Comments: | 4 | Pulse: | | Sevenity: |
| | ON Deskit | Full ROM: | COUPLINGS | miga sa |
| If no, would you like to talk to | 04 5 52 7 | Ext Deformity: | Radiation (arrow above) | Comments: |
| ON D sey I Vould would be to talk to | APPENDENCE OF THE PROPERTY OF | | (2400E BOIONO) HOUTEOUT | Crav Para Ab |
| living environment? | | the state of the s | Location (circled above) | ☐ Scant Moderate ☐ Large Grav Para Ab |
| Do you feel safe in your present | N D X D | Sensation Intact: | 00 00 | Vaginal Discharge ☐ Yes ☐ No |
| | ип х п | Pulse: | HH } ! ! { { | Vaginal Bleeding |
| □ Combative □ Anxious | N 🗆 Y 🗆 moite | Full Range of Mo | / | Bleeding: |
| Cooperative Disoriented | | Comments: | | Frequency |
| Eye Contact X D N Affect: Mormal Flat | ON - SOL INO | , 1 | | Pain in Voiding: Yes No |
| | -N - 30 - 10 - 10 - 10 - 10 - 10 - 10 - 10 | Size(s): | 图一个图人图 | STEEN CONCESSES |
| = ausingesző kinonomák = | | .(5)62;5 | | |
| Slurred Speech? □ Yes □ No | | Location(s): | | Comments: |
| ☐ ☐ Juseant ☐ | (9) 100 | - encija | 11,4 | tn∋sdA □ |
| Strong | | GCS Total (3-15 | | Bowel Sounds: Present |
| | No Response 1 | ro rdrivo o ver | | □ Vorniting □ Diarrhea □ Constipation □ LBM: |
| y tetuloval 🗆 🖊 | toproste Words S Sensible Sounds S | Response Inappre | waynaar (mfyy wyn y | □ Distended □ Nausea |
| Movement: \rightarrow Voluntary | ented/Converses 4 | Verbal Disorie | Pain/Injury Location | Service Servic |
| Visual Acuity: 🔼 WA OD: OD: | (5) səsrəvno O\bətnə | Best Orio | | |
| Size: L: | No Response 1 | mroorooo a) | Comments: | Comments: |
| Monreactive \square \square \square R | Extension 2 (Aribini 8 a. | (Весетертат | Capillary Refill: 🗖 Quick 🛘 Slow | Dyspnea? 🗆 Yes 🗖 No |
| A I I I daigguls | e Rigidity) | (Decorticate | JVD: \[\text{Yes \ \alpha\lambda} \] | Sternar Retractions? \ Yes \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ |
| ☐ Inappropriate Response Pupils: Brisk ☐ L ☐ R- | 4 lswarbhitw-noix 5 lsmnondA\noixə | | Edema: □ Yes ☑ No | Cough: My D Productive |
| Sample Response | Cocalizes Pain 5 | Kesbonse | ☐ Cyanotic ☐ Jaundice | ☐ Rhonchi ☐ Rales ☐ Wheezes |
| Orientation: | Opeys 6 | Best Motor | ☐ Dasky ☐ Flushed ☐ Pale | Breath Sounds: A Bil. Clear |
| ☐ Unresponsive ☐ Lethargic | No Response 1 | | Color: Normal Pink | □ Deep |
| A Alert D Responds to Voic | 6 binamiand 37 Pain 2 | N O T | ☐ Hot ☐ Diaphoretic ☐ Cold ☐ Clammy | □ Shallow |
| | Spontaneously 4 | Eyes Open: | Skin: Warm Dry | Respirations: Regular |
| इंदर्ग के कि कि कि कि कि कि कि कि कि | <u> </u> | J | Créalation : | A STATE OF THE STA |
| | Comments: | A CONTRACTOR OF THE CONTRACTOR | | |
| nt weight loss or gain? 🗆 Y 🗹 f | | NC Mask | Rate: Site: | IV Fluids: Airway: None Oral DET |
| | Are you on a regular | | neboard: Dressings Dressings Pater | |
| N L 17 L 67-17 | | | Descriptor Districts Districts | die 3 Proffe S feet en 2 |
| inspiezozzki knoi | THUNDS: | | All members | |
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| | | AQ7 | Allergies: 1018 | Initial Contact Time: 1030 |
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| ie □ Kez □ No_ | ge Same as Stated Ag | Developmental Ag | | |
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| Juaussas | sA <u>pristy</u> V _s | | | |
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Wuegrass Medical Center

| Pain Intensity: Pain Inten | | | <u>CV-UU452-I</u> | VIEF- | <u> JSC</u> | <u>Doc</u> | ument 1 | | <u>Filed 08/0</u> | <u>7/2006 </u> | Page 1 | <u>08 of 134</u> | (2012C08C08F3) |
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| Vital Signs Procedure Treatment Time Inf | Interventi | ion: | | 1/2 | Interve | ntion: | | | | Intervention | on: | | · · · · · · · · · · · · · · · · · · · |
| Time | | · · · · · · · · · · · · · · · · · · · | | | | · | | | Initials: | | | Initia | ls: |
| Description | | | | Vita | l Signs | | | | | Procedure | e/Treatme | nt Tim | e Ini |
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| Bolice Med. Examiner | | | | Viirce | c Notes | | | | | | Time: 1/ | JK RIA | |
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| Intake: IV Output: NG PO Urine Other Other | | | | | | | * | | | | _ | | |
| PO Urine Other Other | | | | | · - · · · · · · · · · · · · · · · · · · | | | | | | | Output: NC | 1 |
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| Jam Bain Ru PB | | | | :/:3 | 4 | | | | | 17am | Sain | 160 | 16B |

WIREGRASS MEDICAL CENTER 1200 W. MAPLE AVE.

ED-OP HOME INSTRUCTION SHEET

| GENEVA, AL 363 | | 1. MEDICAL F | ECORD NO. | 2. BILLING NO. | | 3. AJR NO. | | |
|--|---|-------------------------------|-------------|---------------------|---|---|--------------------|--|
| (334) 684-365 | 5 | | | | | | | |
| | | ļ | 4. CLASS | 5. DATE | INFO | RMATION 17. SRC | 8. TYPE | 19. SAD |
| And the second s | And the second second | | 1. 02.00 | | | | | |
| 10. PATIENTS LEGAL NAME (L.F.MI) | SEX 12. RACE 13. BIRTHDATE | 14. AC | iE | 15. HEIGHT | 16. WEIGHT 17. S | S 18. MS 19. | • | |
| | Tan House True | Las Wook Till | | 24. HOW PATIENT ARR | INCO | | | |
| 20. BR (21. NOTIFY WITHERGENCY | 22. HOME TELE | 23. WORK TELE | | 24. HOW PATIENT ARK | HAFTI | | | |
| 513688 KRAFT KURT D | | 1 | | ITD ATICAL | CUBOEDVINE | ODMATION | | |
|) 85. ¢ componit 26 (7 8 7 7 7 2 8 MALE 06/04/05 | 27. PROC CD | 28. PROCEDURE | U | JIPAHENI | SURGERY INF | Z9. LOC | 30. TIME | 31. ANES |
| JO / U 4 / U D | 33. ATTENDING PHYSICIAN | 1 | | | T34. FAMILY PHYSICIAN | | | |
| . 6 \ 8 0 0 k | | | | | | | | |
| 47×004 | | | | | | | | |
| | | | | | | | | |
| SPRAIN, FRACTURE, & SEVERE BRUISES | BACK AND NEC | CK INJURY IN | STRUC | TIONS | н | EAD INJURY | INSTRUCTION | ONS |
| ☐ Elevate the injured part above level of heart to lessen swelling. If pillows | USE HEAT OR COLD ON TH | HE INJURED AREA | - whicher | ver seems to helo | Persons who receive | hlows to the hea | d may have injur | ries that cannot alwa |
| flatten, use chair cushions with pillows or blanket for comfort. | the most. Be careful not to | | | | be seen by X-ray or | examination soon a | after accident. I | For the next 24 hours |
| lce packs also help prevent swelling, especially during the first 48 hours. | Rest as much as possible u | | | | is important that the | | | t, to be sure he know |
| ☐ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use heat☐ If you have an elastic bandage, rewrap it if too tight or loose. Remove at | | | • | | where he is and Check eyes to se | | are of equal siz | ·p |
| hedrime and replace in A.M. | Gentle but firm massage wi | • | | | Prevent the takir | g of sleeping pills, | | |
| ☐ If you have a cast, keep it perfectly dry at all times. | helps to clear the screness. | | | | Restrict excessiv | e work or play. <i>loctor or local hos</i> | pital immediatel | ly if the patient: |
| Wiggle toes or fingers to help prevent swelling in the cast—this should be done often if it does not cause pain. | Wear special collar when ou | ut of bed. | | | Develops a sever Vomits more than | | hort time. | |
| ☐ If the part swells anyway or gets cold, blue or numb or pain increases | | | | | ☐ Is confused, faint☐ Has a pupil of on | s or is hard to aw | raken. | |
| markedly, have it checked promptly. Use crutches. | | | | | Complains of dou | ble vision | | -Walanda Alda A |
| G OSE CHARCINES. | | \ | | | ☐ Shows abnormal | behavior such as : | staggering or wa | alking into things. |
| X-RAY INSTRUCTIONS | WOUND CARE (Cut | brasions, | Burns, | Stitches) | | VOMITING 8 | DIARRHEA | |
| Your X-rays have been read by the attending physician in the Emergency | Reep the dressings clean an | • | | | Do not feed anyth | ning for 4 hours. | | |
| Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called | Elevate the wound to help re Despite the greatest care, at | | | - | After 4 hours, if t | here is not vomitin | g and/or diarrhe: | a, offer 2 tablespoons ke, Gingerale, 7-up, |
| to your attention, you and your doctor will be called immediately. (Please be | becomes red, swollen, shows | s pus or red streak: | s, or feels | more sore instead | weak tea, Gatora | de or Jello, water | . If patient is hi | ungrey you may add |
| certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays | of less sore as days go by, y Dressing should be changed | | | or right away. | teaspoon of sugar | | • | PRODUCTS |
| for several days. If your symptoms continue or get worse, call your doctor. | ☐ Treatment rendered | m uo | · 3. | | ☐ The 2 tablespoons | | | |
| More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the | ☐ Tetanus Toxiod given | | | | vomiting has occu | • | | |
| doctor's office. Please call ahead to X-ray Dept. | 250 units of tetanus immune immunization, you must rece | ive two additional | doses of | | Using no more that treatment for 24 | | es) of liquid at a | a time continue this |
| | weeks apart. Call your phys Warm soaks to area 4 times | | | tima | Contact your doct | or's office for fur | ther instructions | after 24 hours. |
| | Continuous warm compresse | • | ites each | Luile. | | | | |
| GENERAL INSTRUCTIONS | FEV | ER OVER 102 | | | | ANIMAL OBS | ERVATION | |
| | | | | | | | | |
| Stay in bed/may go to bathroom. Use vaporizor. | Sponge with lukewarm wate If temperature increases or p | | rs, see vo | ur family doctor. | Instructions for observe that animal is available | | iai inai may nav | e dicten a numan ir |
| Drink large amounts of liquids. | , | | | · | Have animal taken | | | |
| ☐ Take aspirin every 4 hours | | | | | If the owner shoul the County Health | | | Vetennarian, notify |
| Avoid any use of injured part. Allow only limited use of the part. | E, | YE INJURY | | | COMAR | 1 G | 1001 | |
| You need not necessarily limit activity. | | | | | COVOIDE | 7. Ta | mi w | |
| Fill Prescriptions given to you from Emergency Dept. and take as | Any eye injury is potentially hAny increasingly severe disco | | sudden im | nairment of | DUNGI | ciar. | NS | , j |
| directed. No driving or any activity requiring mental alertness after receiving | vision should be reported imm | nediately to your p | hysician o | r eye specialist | 11,0 | | INDPI | se t |
| medication. | below. Do not drive with eye patch. | | | | | | Y IT CC | 1001 |
| 1010110 | C. A. ICC | A | 76 F | 2010 | HAY MIN | LOAT | hor | SIM |
| ADDITIONAL/INSTRUCTIONS \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | 1 Meg. | 7.0 | | J. V. | 101 W | W U | IN | SIGHT |
| or muchor Retur | M TO EX | US Y | KC. | Wa | paired EMERCE | NCV trantm | ont only or | od that I |
| I hereby acknowledge receipt of all the inst may be released before all my medical prob | ructions indicated abo lems are known or trea | ve. Tunders ated. I will a | rrange | for follow-u | ip care as indica | ted above. I | understan | nd that if |
| my conditions worsen or new symptoms a | appear, I should contac | t my Doctor | imme | diately. | | | | |
| PATIENT PARENT'S SIGNATURE | NURSE'S SIGNATURE | 11. | | | PHYSICIAN'S SIG | NATURE / | 11/00 | - |
| JAURYS Non | | MARK | Nx 1 | WM | ノ | - Ulell) | 4105 | |
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| Light work for days | | | | al Educati | | days | | |
| May return to work on | | ∟ May | / retur | n to schoo | on | | | |
| WIREGRASS MEDICAL CENT | TER PHYSI | CIAN'S SIGN | ATURE | | | | | |

ADVANCE DIRECTIVE

AÇKNOWLEDGEMENT

| NAME: Nunn Jovel | SOC. SEC. NO: 422-84-7896 |
|--------------------------|-------------------------------|
| IDENTIFICATION NO. 51348 | DATE OF BIRTH: 01 - 08 - 1977 |

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

- 1. I have been given written materials about my right to accept or refuse medical treatments
- 2. I have been informed of my rights to formulate Advance Directives.
- 3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.
- 4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

| ☐ I HAVE executed an Advance | Directive. |
|------------------------------|---------------------------|
| I HAVE NOT executed an Ad | vance Directive. |
| Signed Mul S. M. | Date: <u>()</u> - 4 - 0 5 |
| Witness: | _ Date: |
| Witness: John Jan | Date: |
| | |

| NA JO! 3688) | PEL RAFT KUF | E.R. RT D | | | Wiregrass Medical Cente ER Level of Service Charge Shee |
|------------------|--|--|-------------------|----------|--|
| 6-01/0 | 8/77 28 | 3 MALE | | | Integumentary |
| /04/05 | | | | 196117 | 60 Repair of Nail Bed |
| | | | - | | 40 Subungal Hematoma |
| /R00# | | | - | 130117 | Dressing Application |
| | | , and the second se | \vdash | 1961013 | 20 FB removal |
| | | | - | | 00 I&D Abcess |
| | | # · · · · · · · · · · · · · · · · · · · | - | | 00 Laceration Repair (simple,intermed) |
| | | Citoviators | | | Do Laceration Complex |
| | | Circulatory Jugular, Cutdown, Central Line | - | | 10 Debridement |
| - | 1063643 | 0 Blood Administration | | | 20 Treatment of Burns |
| | | | 4 | | Orthopedics |
| - | | 0 Cardioversion, Mechanical | | | Behr Block/Regional Block |
| <u> </u> | | 0 Code Blue | | 1062050 | |
| <u> </u> | | 3 External Pacemaking | | | 0 Casting/Splinting 5 Removal or Revision of Cast |
| _ | | 0 Intubation | | 1962970 | |
| L | | 1 Vacine Admin. (other than Rabies) | | 100000 | Tx of fx/dislocation with manipulation |
| L_ | | 5 Vacine Administration (Rabies) | | 1962095 | 0 Compartmental Syndrome |
| | | 4 Medication Administration IV | | | Neurological Neurological |
| / X | | 2 Medication Administration IM or SQ | | 1966229 | 0 Lumbar Puncture |
| 4 | | IV infusion-up to 1 hour | | | |
| L | | I IV infusion-each additional hour | | | |
| | 19649080 | Paracentesis | | | |
| | | Peritoneal Lavage/Tap | | | |
| | 19632000 | Thoracentesis | | | |
| | 19633010 | Pericardiocentesis | | | |
| | 19632002 | Chest Tube Insertion | | | |
| | | IV Hydration | 1.0 | 11.0 | Other . |
| | | | | 19682962 | 2 Glucose fingerstick |
| | | ENT | | | |
| | | Eye Irrigation | | | |
| | | Eye Exam/Corneal Abrasion | Т | | |
| | | Foreign Body Removal Ear | - | | |
| | | Foreign Body Removal Nose | | | |
| | | Irrigation Ear | | | |
| | | Nose Bleed/Nasal Packing | | | |
| | | Rust Ring (Foreign Body Removal) | | 100 | Treatment Level: |
| | | Respiratory | | 19699211 | Low Level E/R |
| 35-9004-000 | 19631603 | Tracheotomy | | 19699281 | Emergency WD |
| | | Cricothyrotomy | 7 | 19699282 | Emergency I |
| | | Trach Change / | | 1 | Emergency I with procedure |
| | | Gastrointestinal | $\overline{\vee}$ | 19699283 | Emergency II |
| **** | | Gastric Lavage or NGT insertion | ~ | / | Emergency II with procedure |
| | | Gastrostomy Tube Placement | | 19699284 | Emergency III |
| | | Genitourinary | | | Emergency III with procedure |
| | att and for in an an antibotic contact | Delivery/Birth | | 19699285 | Emergency IV |
| | | Supra Pubic Cath, or Turkey Tray | | | Emergency IV with procedure |
| - | | Irrigation of Catheter | | 19699291 | Critical Care |
| - | | Pelvic Exam | | ,0000201 | Critical Care with procedure |
| | | GIVIC LAGITI | | | Observation I |
| ļ | | | - | | Observation II |
| | | | | | Observation III |
| L | | | | | Obdo: validir iii |

| 513666 | OMEL. E. KRAFT KURT D | R. | Eı | mergency Physician's Char | ge Sr | ieet | Date: |
|--|-----------------------------------|---|--|------------------------------------|--------------|-------------|--|
| | '08/77 28 MALE | | San Control of the Co | Debridement | | | |
| 06/04/0 | | | | 0 Infected Skin | | | e, Ears, Eyelids, Nose, Lips, |
| | | L | | Partial Skin Thickness | | | d/or Mucous Membranes |
| ER/ROOM | | <u> </u> | | 1 Skin, Full Thickness | | | 11 2.5 cm or less |
| _ | | ļ | | 2 Skin and Sub Q Tissue | | | 13 2.6 - 5.0 cm |
| | | ļ | | Skin, Sub Q, Muscle | | | 14 5.1-7.5 cm 15 7.6 - 12.5 cm |
| | | | | Skin, Sub Q, Muscle, Bone | | | |
| Charles and Charle | Level of Service | | AT A SAME OF THE PARTY OF THE P | lematoma and Abcess | | | 16 12.6 - 20.0 cm 17 20.1 - 30.0 cm |
| 1 | 281 Level I | | + | 1&D Simple Abcess, Furuncie | + | | 18 Over 30.0 cm |
| | 282 Level II | | 19510061 | I&D Simple Abcess, Complicated/ | - | | 20 Superficial WD Dehis |
| | 283 Level III | | 10510110 | Multiple | +- | | 21 Superficial WD Dehis-Pack |
| | 284 Level IV | | + | I&D Hematoma Simple | | | air/Intermediate-Layered |
| | 285 Level V | - | | I&D Puncture Aspiration, Abcess | | | illae, Trunk, and/or Extremities |
| | 88 Direct Life Support In Transit | | | Hemorrhoid, Thrombosed | - | | 31 2.5 cm or less |
| | 25 Visit with Surgery | - 100 | | Burns | | | 32 2.6 - 7.5 cm |
| | 91 Critical Care per Hour | | | First Degree Burn, Initial | - | | 34 7.6 - 12.5 cm |
| | 92 Critical Care per 1/2 hour | | | Small Burn, Debride, Dress | | | 5 12.6 - 20.0 cm |
| | 05 NG Lavage/Aspiration | - | | Medium Burn, Debride/Dress | | | |
| 195991 | 75 Ipecac Admin/Observe Gastric | | L | Large Burn, Debride/Dress | | | 6 20.1 - 30.0 cm |
| | emptying | | 1 | DB/GYN Procedures | - | | 7 Over 30.0 cm |
| | Airway/Pulmonary | | | I&D, Abcess, Vulva | | | , Feet, and/or External Genitalia |
| | 00 Endotracheal Intubation | <u> </u> | | I&D, Bartholin Abcess | | | 1 2.5 cm or less |
| 195315 | 11 FB Removal | | | Emergency Vaginal Delivery | | | 2 2.6 - 7.5 cm |
| | 20 Tube Thoracostomy | 201100000000000000000000000000000000000 | | Arthrocentesis | | | 4 7.6- 12.5 cm |
| | Vascular Procedures | | | Arthrocentesis, Small Joint | | | 5 12.6 - 20.0 cm |
| 1953641 | Non-Routine Venipuncture | | 19520605 | Arthrocentesis, Intermediate Joint | | + | 6 20.0 - 30.0 cm |
| 195907 | IV Therapy Requiring MD | | | Arthrocentesis, Major Joint | | | 7 Over 30.0 cm |
| | per hour | | Mis | cellaneous Fractures | | | Ears, Eyelids, Nose, Lips, |
| | 7 Thrombolysis IV infusion | | 19521800 | Closed Rib Fracture | ļ | | or Mucous Membranes |
| 1.0 | Cardiac Procedures | | 19523500 | Clavicle | | | 2.5 cm or less |
| 1959295 | 0 CPR | | 19523720 | Closed Phalangeal Shaft | | | 2.6 - 5.0 cm |
| 1959295 | 3 Transcutaneous Pacing | | 19526750 | Closed Distal Phalangeal | | 19512053 | 3 5.1 - 7.5 cm |
| 1959296 | Cardioversion, Elective | | 19528490 | Closed Fracture, Great Toe | | 19512054 | 7.6 - 12.5 cm |
| 1959301 | 0 EKG Interpretation | | 19528510 | Closed Phalanx other than Gr. Toe | | 19512055 | 12.6 - 20.0 cm |
| | Ophthalmology | | | | | 19512056 | 20.1 - 30.0 cm |
| 1956520 | 5 FB | | Miscellar | eous Closed Dislocations | | 19512057 | Over 30.0 cm |
| 1956521 | FB Conjunctival/Embedded | | 19521480 | TMJ Uncomplicated | | | |
| 19567938 | FB, Eyelid | | 19523650 | Shoulder w/ Manipulation | - | • | omplex-Reconstructive or |
| В | ar,Nose, and Throat | | 19524640 N | lursemaid's Elbow | | Comp | licated Wound Closure |
| | FB Pharynx | | 19526700 F | inger, MP Joint | <u></u> | | Trunk |
| | FB External Ear Canal | | 19526770 F | inger, IP Joint | | 19513100 | 1.1 - 2.5 cm |
| | Impacted Cerumen | | 19528660 T | oe IP Joint | | 19513101 | 2.6 - 7.5 cm |
| 19530300 | FB Intranasal | | Misce | ellaneous Procedures | | Sca | lp, Arms, and/or Legs |
| | Anterior Epitaxis, Simple | | 19553670 U | Irine Catheterization, Simple | | | 1.1 - 2.5 cm |
| | Anterior Epitaxis, Complex | | 19553675 U | rine Catheterization, Complex | | 19513121 | 2.6 - 7.5 cm |
| | Posterior Epitaxis, Initial | | 19562270 S | pinal Puncture | | Forehead, | Cheeks, Chin, Mouth, Neck, |
| | ue/Foreign Body Removal | | 19564450 D | igital Block | | Axillae, G | enitalia, Hands, and or Feet |
| | Sub Q, Simple | | 19582270 S | tool for Occult Blood | | 19513132 | 1.1 - 7.5 cm |
| | Sub Q, Complicated | - · | 19593042 R | hythm Strip Interpretation | | Eyelids, | Nose, Ears, and/or Lips |
| | Muscle, Simple | | Repair | /Simple-Single Layer | | 19513151 | 1.1 - 2.5 cm |
| | | Scalp, I | Neck, Axillae | e, External Genitalia, Trunk, | | 19513152 | 2.6 - 7.5 cm |
| | Nails | • * | | extremities | | | |
| | Avulsion/Nail, Simple | T 1 | 19512001 2. | | | | |
| | Subungal Hematoma | | 9512002 2:0 | | | | • |
| 10012140 | Japan Hamatania | | 9512004 7.6 | | | | |
| + | · · · | | 9512005 12 | | | | |
| | | | 9512006 20 | | | | |
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WIREGRASS MEDICAL CENTER

1200 W MAPLE AVE

| ATIENT NUMBER | TYPE | PATIENT NAME | | | 1 - | | RTHDATE | | SEX | M/S | DATE OF SI | RVICE | TIME | CLERK IN |
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Wiregrass Medical Center 1200 W. Maple Avenue Geneva, Alabama 36340

NUNN JOWEL 513811 MCLEOD JIMMY W MD DOF-01/08/77 28 06/06/05

CONDITIONS FOR TREATMENT

- MEDICAL AND SURGICAL CONSENT FOR TREATMENT: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to furnish the necessary treatment, surgical procedures, anesthesia, x-ray examinations or treatments, drugs and supplies as may be ordered or requested by the attending physician(s). The undersigned acknowledges that no guarantee or assurance has been made as to the results of treatment, surgery or examinations in the hospital. The undersigned recognizes that all physicians furnishing services to the patient may be independent contractors and are not employees or agents of the Hospital.
- RELEASE OF INFORMATION: The undersigned hereby authorizes WIREGRASS MEDICAL CENTER to release to any insurers, their representatives or other third parties confidential information (including copies of records) relative to this hospitalization. This authorization includes, but is not limited, to the release of information relating to drug, alcohol and or psychiatric treatment as specified in Federal Regulation 42, CFR part 2. I further authorize any physician or institution that attended the patient previously to furnish medical records or information which may be requested by the Hospital or attending physicians.
- RELEASE FROM LIABILITY FOR VALUABLES: I have been made aware the WIREGRASS MEDICAL CENTER provides facilities for the safe keeping of my valuables and therefore, I release the Hospital from any responsibility due to loss or damage of my clothing, money, jewelry, or other items of value that I might keep at my bedside, or that may be brought to me by my friends and relatives.
- GUARANTOR AGREEMENT: The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the Hospital in accordance with the regular rates and terms of the Hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense. All delinquent accounts bear interest at the legal rate.
- ASSIGNMENT OF INSURANCE BENEFITS: In the event the undersigned and/or patient is entitled to Hospital benefits of any type whatsoever arising out of any insurance policy or any other party liable to the patient, such benefits are hereby assigned to WIREGRASS MEDICAL CENTER for application to the patient's bill. It is agreed that the Hospital may receipt for any such payment and such payment will discharge the said insurance company of all obligations under the policy to the extent of such payment. The undersigned and/or patient agrees to be responsible for charges not paid by this assignment.

THE UNDERSIGNED CERTIFIES THAT HE HAS READ OR HAD THE FOREGOING INFORMATION EXPLAINED, HAS RECEIVED A COPY, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL/AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

| | 6 - 6 20 O | 5 V (Jegy of) S. M. |
|--|--|--|
| Date | hlen Highe | Patient |
| withess | d O | Patient's Agent or Representative |
| | | Relationship to Patient |
| 1 | | OF MEDICARE BENEFITS: I TO RELEASE INFORMATION, AND PAYMENT REQUEST |
| or other information about the dicare claim. I require such physician or organ | out me to release to the Social Security Admin est that payment of authorized benefits be ma nization to submit a claim to Medicare for paym | der title XVIII of the Social Security Act is correct. I authorize any holder of medical istration or its intermediaries or carriers any information needed for this or a related ade on my behalf. I assign the benefits payable for physician services or authorize nent to me. I understand that I am responsible for Part A deductible for each spell of sonable charges and any personal charges incurred." |
| Date | Signature | Relationship to Patient |
| | ACKNOWLE | DGEMENT OF MEDICARE |
| I hereby declare I am a group practice. I unders to pay in full immediately | tand that if it is found that I am a participant in a | not enrolled in a health maintenance organization, (H.M.O.), or any other pre-paid any of the above mentioned practices, I will be considered a self-pay patient required |
| Date | Signature | Relationship to Patient |

Coder: TRACEYM

WIREGRASS MEDICAL CENTER

Billing Form

For Financial Class:

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| Pati | ent Name. | | NUNN, JOWEL | Discharge Da | te | 06/06/2005 |
|-------------------------------|--------------------------------------|------------------------------|------------------------------|----------------|-----------|-------------|
| Adn | nission Dat | e | 06/06/2005 | Date of Birth | | 01/08/1977 |
| Med | lical Recor | d Number | 422847896 | Sex | | Male |
| Age | • | | 28 | | | |
| Acc | ount Numb | er | 513811 | | | |
| | | | | | | |
| <u>DX</u> | <u>Code</u> | DX Description | | | | |
| 1 | 707.8 | Chronic Ulcer of Skin | | | | |
| 2 | 041.11 | • | Site NOS/Dis Class Elsewhere | , | | |
| 3 | V09.0 | Penicillin-Resistant M | licroorganism Infection | | | |
| PR | Code | PR Description | | Procedure Date | Surgeon | |
| <u> </u> | <u>ooue</u> | 111 Description | | 11000daio Daio | | |
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& Joel Nun 1-8-77

Wiregrass Medical Center

| Addressograph | ER Medical Re | cord | () Emergent (| Urgent (/) | Non-Emerge |
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| (2) Instructions: Local Ca | 1 -> / | | | | |
| | Eu 3-4 day | <u> </u> | | | · · · · · · · · · · · · · · · · · · · |
| Signing this form denotes that I have revie | wed all information on this docume | at and I | | | , , , , , , , , , , , , , , , , , , , |
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| | | | | | | | · · · · · · · · · · · · · · · · · · · | Marce | de Ciono | thire/Title | • | Init |
| | | | | | | | | 140100 | , <u> </u> | | | ************************************** |
| | | · · · · · · · · · · · · · · · · · · · | | | | | | | <u>abb</u> | ghis R | | Ut |
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EB\BOOM:

WIREGRASS MEDICAL CENTER 1200 W. MAPLE AVE.

ED-OP **HOME INSTRUCTION SHEET**

| GENEVA, AL 36 | | 1. MEDICAL RE | CORD NO. | 2. BILLING NO. | | 3. A/R NO. | |
|---|---|--|---|---|---|---|--|
| (334) 684-363 | | | | INFORM | ATION | | |
| | | 4. CLASS | 5. DATE | 6. TIME | 7. SRC | 8. TYPE | 9. SAD |
| N 10 PATRITIS LEGALMANE (LF MI) 5 1 3 8 1 1 M C L E O D J I M N Y W M D 20 PR 20 NOTIFY INCENSES PC 7 7 2 8 M A L F 0 6 / 0 5 / 0 5 25 C COMPANIT 26 | | ORK TELE 2 | 5. HEIGHT 4. HOW PATIENT ARF | ··· | 18. MS 15 | | |
| | 27. PROC CD 28. PRO | OCEDURE | TPATIENT | SURGERY INFOR | MATION 129. LDC | 30. TIME | 31. ANES |
| ERICON M 32. PHYSICIAN CALLED | 33. ATTENDING PHYSICIAN | | | 34. FAMILY PHYSICIAN | | | OT. AIRCO |
| | | | | | · · · · · · · · · · · · · · · · · · · | | |
| SPRAIN, FRACTURE, & SEVERE BRUISES | BACK AND NECK INJ | JURY INSTRUCT | IONS | HEAD | INJURY | INSTRUCT | IONS |
| □ Elevate the injured part above level of heart to lessen swelling. If pillows flatten, use chair cushions with pillows or blanket for comfort. □ Ice packs also help prevent swelling, especially during the first 48 hours. □ Place ice in plastic or rubber bag, cloth covering; after 48 hours, use hea □ If you have an elastic bandage, rewrap it if too tight or loose. Remove at bedtime and replace in A.M. □ If you have a cast, keep it perfectly dry at all times. □ Wiggle toes or fingers to help prevent swelling in the cast—this should be done often if it does not cause pain. □ If the part swells anyway or gets cold, blue or numb or pain increases markedly, have it checked promptly. □ Use crutches. | the most. Be careful not to burn y Rest as much as possible until you t. Avoid positions and movement that | ourself. are improved. I make the pain worse. I the problem will on buse se circulation in sore n | e worse. | Persons who receive blow be seen by X-ray or exam is important that these in Awaken the patient e where he is and is not Check eyes to see that Prevent the taking of Restrict excessive wo Call your family doctor Develops a severe heat Vomits more than twictor Is confused, faints or it Has a pupil of one eye Complains of double vit | ination soon a structions be very two hou t confused. It both pupils sleeping pills, rk or play. r or local hos dache. e within a si s hard to aw larger that ti | after accident. followed: rs, even at nigl are of equal si tranquilizers o pital immediate oort time. aken. he other | For the next 24 hours ht, to be sure he know ze. r alcohol. |
| X-RAY INSTRUCTIONS | WOUND CARE (Cuts, Abr | rasions, Burns, S | titches) | vo | MITING & | DIARRHEA | 4 |
| Your X-rays have been read by the attending physician in the Emergency Dept. For your added protection, your X-rays will be reread the next morning by Radiology Dept. If any abnormalities are found that have not been called to your attention, you and your doctor will be called immediately. (Please be certain that the Emergency Dept. has a phone number where you can be reached.) Sometimes fractures or abnormalities may not show up on X-rays for several days. If your symptoms continue or get worse, call your doctor. More X-rays may need to be taken. If you are referred to another physician, come by the hospital and pick up your X-ray and take them with you to the doctor's office. Please call ahead to X-ray Dept. | □ Keep the dressings clean and dry. □ Elevate the wound to help relieve sor □ Despite the greatest care, any woun becomes red, swollen, shows pus or r of less sore as days go by, you must □ Dressing should be changed in □ Treatment rendered □ Tetanus Toxiod given □ 250 units of tetanus immune globulin immunization, you must receive two weeks apart. Call your physician for □ Warm soaks to area 4 times daily. 20 □ Continuous warm compresses. | d can be infected. If yed streaks, or feels mot report to your doctor days. I was given. To compladditional doses of tox the next dose. | your wound ore sore instead right away. ete your oid 4-6 | □ Do not feed anything for After 4 hours, if there is (1 ounce) of any of the weak tea, Gatorade or teaspoon of sugar to eta UNDER NO CIRCUMST. □ The 2 tablespoons of licum vomiting has occured, to treatment for 24 hours. □ Contact your doctor's of the sugar team | s not vomiting following: c Jello, water. ach ounce of ANCES USE A puid may be o the amount m plass (4 ounce) | lear liquids, Co If patient is h liquid. ILK OR MILK I Ifered every ho ay be slowly in es) of liquid at | ke, Gingerale, 7-up, ungrey you may add 1 PRODUCTS. our. If after 4 hours no creased. a time continue this |
| GENERAL INSTRUCTIONS | FEVER OVI | ER 102 | | ANII | MAL OBS | ERVATION | |
| □ Stay in bed/may go to bathroom. □ Use vaporizor. □ Drink large amounts of liquids. □ Take aspirin every 4 hours | ☐ Sponge with lukewarm water in the t☐ If temperature increases or persists fo | | family doctor. | Instructions for observation of any animal that may that animal is available for observation. Have animal taken to Vetennarian for observation If the owner should refuse to take the animal to | | | |
| □ Avoid any use of injured part. □ Allow only limited use of the part. □ You need not necessarily limit activity. □ Fill Prescriptions given to you from Emergency Dept. and take as directed. □ No driving or any activity requiring mental alertness after receiving medication. | Any eye injury is potentially hazardous Any increasingly severe discomfort, revision should be reported immediately below. Do not drive with eye patch. | s. dness or sudden impai | | the County Health Office | er of the situa | tion. | |
| ADDITIONAL INSTRUCTIONS and Bac Doaper water - dry - apply our hereby acknowledge receipt of all the instrumay be released before all my medical problemy conditions worsen or new symptoms as AMENT/PARENT'S SIGNATURE | t furce a day of ructions indicated above 1 u | and Cove | t I have rec | eived EMERGENCY | treatme | nt only an | id that I |
| SCHOOL AND WORK EXCUSE PATIEN | T NAME | | | | DATE | 7 | İ |
| ☐ No work for days ☐ Light work for days ☐ May return to work on | | No school f No Physical May return | Educatio | n for day | s | | |

ADVANCE DIRECTIVE

ACKNOWLEDGEMENT

| NAME: NUMM, JOWEL | SOC. SEC. NO: 422847896 |
|------------------------|-------------------------|
| IDENTIFICATION NO: 531 | DATE OF BIRTH: 1-8-77 |

PLEASE READ THE FOLLOWING FOUR STATEMENTS.

- 1. I have been given written materials about my right to accept or refuse medical treatments
- 2. I have been informed of my rights to formulate Advance Directives.
- 3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility.
- 4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by law.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ I HAVE executed an Advance Directive.

| HAVE NOT executed an Adv | vance Directive. |
|--------------------------|------------------|
| Signed Jour 5 | Date: 6-6-05 |
| Witness: | Date: |
| Witness: ashly Hughes | Date: 6-6-05 |
| \circ | |

| N I | L NHI | n W F | i E | , R | • | | | rass Medical Center | | . | Defer |
|---|--|---------------------|--|-----------------|--|--|---|-----------------------------------|------------|--------------|------------------------------------|
| K : | 7911 | M C | LEOD JINMY W MC | ì | | | | ergency Physician's Char | | | Date: |
| יות נכ | 10-01 | 100 | 3/77 28 MALE | | | | | Debridement | | | |
| | 5/0.6/ | | .,,,, | | 1 | 195110 | 000 | Infected Skin | | | e, Ears, Eyelids, Nose, Lips, |
| Ų t | 37 007 | <i>y y</i> | | | | | - | Partial Skin Thickness | | | nd/or Mucous Membranes |
| ro | R/R 00 P | М | | | 1 | 95110 | 041 | Skin, Full Thickness | | | 011 2.5 cm or less |
| 2 7 | () 1 (0 0 i | . 1 | | | 1 | 95110 |)42 | Skin and Sub Q Tissue | _ | 19512 | 013 2.6 - 5.0 cm |
| | | | | | 1 | 95110 |)43 | Skin, Sub Q, Muscle | | 19512 | 014 5.1-7.5 cm |
| | | | | | 1 | 95110 |)44 | Skin, Sub Q, Muscle, Bone | | 19512 | 015 7.6 - 12.5 cm |
| | | | Level of Service | | 1777 | | He | matoma and Abcess | | 19512 | 016 12.6 - 20.0 cm |
| | | | Level | | 1 | 95100 | 1 00 | I&D Simple Abcess, Furuncle | | 195120 | 017 20.1 - 30.0 cm |
| | 19599 | 282 | Levell | | 11 | 95100 | 61 | &D Simple Abcess, Complicated/ | | 195120 | 018 Over 30.0 cm |
| | | | Level III . | | | | 7 | Multiple | | 195120 | 020 Superficial WD Dehis |
| | 19599 | 284 | Level IV | | 19 | 951014 | 40 1 | &D Hematoma Simple | | 195120 | 021 Superficial WD Dehis-Pack |
| | 19599 | 285 | Level V | | 19 | 951016 | 60 1 | &D Puncture Aspiration, Abcess | | Re | air/Intermediate-Layered |
| | 19599 | 288 | Direct Life Support In Transit | $\neg \uparrow$ | | | _ | Hemorrhoid, Thrombosed | | | xillae, Trunk, and/or Extremities |
| | | | Visit with Surgery | | | | | Burns | | 195120 | 31 2.5 cm or less |
| - | | | Critical Care per Hour | | ****************************** | | 200000000000000 | First Degree Burn, Initial | | | 32 2.6 - 7.5 cm |
| - | | | Critical Care per 1/2 hour | \dashv | | | - | Small Burn, Debride, Dress | | | 34 7.6 - 12.5 cm |
| | | -+ | NG Lavage/Aspiration | \dashv | | | | Medium Burn, Debride/Dress | | | 35 12.6 - 20.0 cm |
| - | | + | pecac Admin/Observe Gastric | _ | | | _ | arge Burn, Debride/Dress | _ | + | 36 20.1 - 30.0 cm |
| | 19599 | _ | • | |] 19 | 1003 | | 3/GYN Procedures | | | 37 Over 30.0 cm |
| | | | emptying | | 140 | EEC 40 | 100000000000000000000000000000000000000 | BD, Abcess, Vulva | | | d, Feet, and/or External Genitalia |
| | 1405045 | OCCUPATION NAMED IN | rway/Pulmonary | | | | _ | | + | , | |
| | | _ | Endotracheal Intubation | - | | | | D, Bartholin Abcess | + | | 41 2.5 cm or less |
| | | | B Removal | | | | | mergency Vaginal Delivery | | | 42 2.6 - 7.5 cm |
| | | | Tube Thoracostomy | | | | | Arthrocentesis | | | 14 7.6- 12.5 cm |
| | | ****** | cular Procedures | | | | - | rthrocentesis, Small Joint | <u> </u> | + | 15 12.6 - 20.0 cm |
| | 1953641 | 0 1 | Non-Routine Venipuncture | \perp | | | - | rthrocentesis, Intermediate Joint | <u> </u> | | 16 20.0 - 30.0 cm |
| | 195907 | 80 N | V Therapy Requiring MD | | CONTRACTOR OF THE PARTY OF THE | Carrelation to the A | 40.500.400 | throcentesis, Major Joint | | | 7 Over 30.0 cm |
| | | P | er hour | | | M | lisce | ellaneous Fractures | | Face, | Ears, Eyelids, Nose, Lips, |
| | | | hrombolysis IV infusion | | 195 | 21800 | OCI | osed Rib Fracture | | and | l/or Mucous Membranes |
| 1.57 | | Car | diac Procedures 📳 💢 | 1 | 195 | 23500 | Cla | avicle | | 1951205 | 1 2.5 cm or less |
| | 1959298 | 50 C | PR | | 195 | 23720 | Clo | osed Phalangeal Shaft | | 1951205 | 2 2.6 - 5.0 cm |
| | 1959295 | 53 T | ranscutaneous Pacing | T | 195 | 26750 | Clo | osed Distal Phalangeal | | 1951205 | 3 5.1 - 7.5 cm |
| | 1959296 | 0 C | ardioversion, Elective | П | 195 | 28490 | Clo | osed Fracture, Great Toe | | 1951205 | 4 7.6 - 12.5 cm |
| | 1959301 | 0 E | KG Interpretation | | 195 | 28510 | Clo | osed Phalanx other than Gr. Toe | | 1951205 | 5 12.6 - 20.0 cm |
| | | O | phthalmology | | | | <u></u> | | | 1951205 | 6 20.1 - 30.0 cm |
| T | 1956520 | | | | M | iscella | anec | ous Closed Dislocations | | 1951205 | 7 Over 30.0 cm |
| | | | 3 Conjunctival/Embedded | | . 1.50.01.01.01.01.01.01.01.01 | arrent arrest and arrent arrest arres | 1 | IJ Uncomplicated | | | |
| - | 19567938 | -+ | | \top | | | + | oulder w/ Manipulation | | Repair/C | omplex-Reconstructive or |
| | | | lose, and Throat + - | | | | - | rsemaid's Elbow | | | Hicated Wound Closure |
| T | | | 3 Pharynx | *** | | | | ger, MP Joint | | | Trunk |
| - | | | B External Ear Canal | +- | | | | ger, IP Joint | <u>†</u> T | 19513100 | 1.1 - 2.5 cm |
| | | + | pacted Cerumen | +- | | | | e IP Joint | | | 2.6 - 7.5 cm |
| - | | + | Intranasal | | 1902 | | | aneous Procedures | | | ilp, Arms, and/or Legs |
| | | | terior Epitaxis, Simple | | 1055 | ···· | | ne Catheterization, Simple | - | | 1.1 - 2.5 cm |
| | | + | terior Epitaxis, Simple terior Epitaxis, Complex | +- | | | | ne Catheterization, Simple | | | 2.6 - 7.5 cm |
| - | | +- | | + | | | | | | | Cheeks, Chin, Mouth, Neck, |
| | | | sterior Epitaxis, Initial | - | | | <u> </u> | nal Puncture | | | |
| *************************************** | | 7 | oreign Body Removal | | - | | | tal Block | | | enitalia, Hands, and or Feet |
| -+- | | _ | Q, Simple | | | | | ol for Occult Blood | | | 1.1 - 7.5 cm |
| | | + | Q, Complicated | | NOTE OF THE PROPERTY OF THE PR | - FRANCISCO ANTONIO | - CONTRACTOR | thm Strip Interpretation | | | , Nose, Ears, and/or Lips |
| | | | scle, Simple | | | | | imple-Single Layer | | | 1.1 - 2.5 cm |
| - Carrier Control Control | and the second s | | scie, Complex | Scal | lp, Neck, | | | External Genitalia, Trunk, | | 19513152 | 2.6 - 7.5 cm |
| | | 1 | Nai s | <u> </u> | · | | | ctremities | | | |
| | 9511730 | Avu | Ision/Nail, Simple | L | 19512 | 2001 2 | 2.5 c | em or less | | | |
| 1 | 9512740 | Sub | ungal Hematoma | | 19512 | 2002 2 | 2.6 - | 7.5 cm | | | |
| \perp | | | | | 19512 | 004 7 | '.6 - | 12.5 cm | | | |
| | | | | | 19512 | 005 1 | 2.6 | - 20.0 cm | | | |
| $\bot \!\!\! \bot$ | | | | | 19512 | 006 20 | 0.1 - | - 30.0 cm . | | | |
| | | | | | 19512 | 007 0 | ver | 30.0 cm | | | |

NUNN JOWEL . E.R. 513811 MCLEOD JIMMY W MD DOB-01/08/77 28 MALE 06/06/05

Wiregrass Medical Center ER Level of Service Charge Sheet

| ER/ROOM | | Agriculture and the second sec | | | ER Level of Service Charge She |
|--------------|--------------|--|-----------------|-------------|---|
| ENTROOM | | | | | Integumentary |
| | | · | Γ | 196117 | 760 Repair of Nail Bed |
| | | • | Γ | 196117 | 740 Subungal Hematoma |
| | | | | | Dressing Application |
| | | | | 196101 | 20 FB removal |
| | | • | | 196200 | 000 I&D Abcess |
| | | | | 196000 | 000 Laceration Repair (simple,intermed) |
| | | Circulatory | 5 | 196100 | 000 Laceration Complex |
| 200 | | Jugular, Cutdown, Central Line | | 196110 | 40 Debridement |
| | 196364 | 30 Blood Administration | | 196160 | 20 Treatment of Burns |
| | | 60 Cardioversion, Mechanical | | 100 | Orthopedics |
| <u> </u> | | 50 Code Blue | | | Behr Block/Regional Block |
| | | 53 External Pacemaking | \top | 196295 | 00 Casting/Splinting |
| <u> </u> | | 00 Intubation | 1 | | 05 Removal or Revision of Cast |
| | | 71 Vacine Admin. (other than Rabies) | \top | | Tx of fx/dislocation with manipulation |
| | | 75 Vacine Administration (Rabies) | \top | 196209 | 50 Compartmental Syndrome |
| | | 34 Medication Administration IV | | | Neurological |
| | | 2 Medication Administration IM or SQ | 1005655 | 1966229 | 0 Lumbar Puncture |
| | | 0 IV infusion-up to 1 hour | + | | |
| | | 1 IV infusion-each additional hour | \top | | |
| · | | 0 Paracentesis | + | | |
| | 1.00,000 | Peritoneal Lavage/Tap | + | | |
| | 1963200 | 0 Thoracentesis | + | | |
| | | 0 Pericardiocentesis | +- | | |
| <u> </u> | | 2 Chest Tube Insertion | 1 | | |
| | 1.00000 | IV Hydration | | | Other 1 |
| | + | | | 1968296 | 2 Glucose fingerstick |
| | | ENT | | | |
| | | Eye Irrigation | | | |
| | | Eye Exam/Corneal Abrasion | | | |
| | † | Foreign Body Removal Ear | | 1 | |
| | <u> </u> | Foreign Body Removal Nose | | | |
| | 1 | Irrigation Ear | | | |
| | | Nose Bleed/Nasal Packing | | | |
| | | Rust Ring (Foreign Body Removal) | | 7.0 | Treatment Level |
| | | Respiratory | | 19699211 | Low Level E/R |
| | | Tracheotomy | | 19699281 | Emergency WD |
| | | Cricothyrotomy | 1/ | 19699282 | Emergency I |
| - | | Trach Change | | · · · · · · | Emergency I with procedure |
| | | Gastrointestinal | | 19699283 | Emergency II |
| | | Gastric Lavage or NGT insertion | | | Emergency II with procedure |
| | | Gastrostomy Tube Placement | | 19699284 | Emergency III |
| | | Genitourinary | | | Emergency III with procedure |
| | | Delivery/Birth | | 19699285 | Emergency IV |
| | | Supra Pubic Cath, or Turkey Tray | | | Emergency IV with procedure |
| | | Irrigation of Catheter | | 19699291 | Critical Care |
| | | Pelvic Exam | | | Critical Care with procedure |
| | | | | | Observation I |
| | | | | | Observation II |
| | | | $\neg \uparrow$ | | Observation III |
| | | | \neg | | |
| | | | | | |